WyoBlue Advantage

PPO Provider Manual

January 2026

This manual is subject to change. To ensure that you review the most current version, we strongly discourage you from relying on printed versions.

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Time saving tip!

Ctrl + Click on any of the blue links below to go directly to that page.

Claims submission guide

Claim source	Contact info	Paper Claim Submission	EDI Claim Submission
Claims from MA Network Providers for MA WyoBlue Advantage members	Phone **1-844-682-9449** Fax **1-855-595-2895**	WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121	Submit through Availity Portal or clearinghouse. WyoBlue Advantage Payer ID: WYBA
Medical claims for non-WY BCBS MA members using WY in-network Blue Cross network sharing providers	Phone **1-844-682-9449** Fax **1-855-595-2895**	WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121	Submit through Availity Portal or clearinghouse. WyoBlue Advantage Payer ID=WYBA
Medical claims for WyoBlue members using Blue Cross network sharing providers outside of WY	Phone **1-844-682-9449**	Submit to provider's home BCBS plan	Submit to provider's home BCBS plan
Medical claims submission from out-of-network providers in WY	Phone **1-844-682-9449** Fax **1-855-595-2895**	WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121	Submit through Availity Portal or clearinghouse. WyoBlue Advantage Payer ID= WYBA
Vision claims for **select** WyoBlue members See Policy Papers for more information	Phone **1-844-682-9966**	Vision Provider: VSP PO Box 495918 Cincinnati, OH 45249-5918	Submit online form on Vsp.com Providers must create a VSP account and log in to access the online form.
Hearing claims for **select** WyoBlue members See Policy Papers for more information	Phone **1-877-921-4559**	Hearing Provider: Nations Hearing 1700 N University Dr Plantation FL, 33322	Email: oonclaims@nationsbenefits.com Fax: 877-391-9637

About this manual

General information

This manual is for use by Wyoming providers only. Many of the provisions do not apply to providers in other states.

If you are an out-of-state provider, for more information, please visit: wyoblueadvantage.com

WyoBlue Advantage plan overview

WyoBlue Advantage is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare & Medicaid Services to offer Medicare Advantage plans in the senior market. WyoBlue Advantage will offer Medicare Advantage coverage to Medicare-eligible Wyoming residents and Medicare-eligible patients of WyoBlue Advantage employer groups.

WyoBlue Advantage plans provide the same level of benefit coverage as Original Medicare Part A and Part B and provide enhanced benefits beyond the scope of Original Medicare within a single health-care plan. This flexibility allows WyoBlue Advantage to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit. You can find these benefit policies on our website at wyoblueadvantage.com/medical-policies.

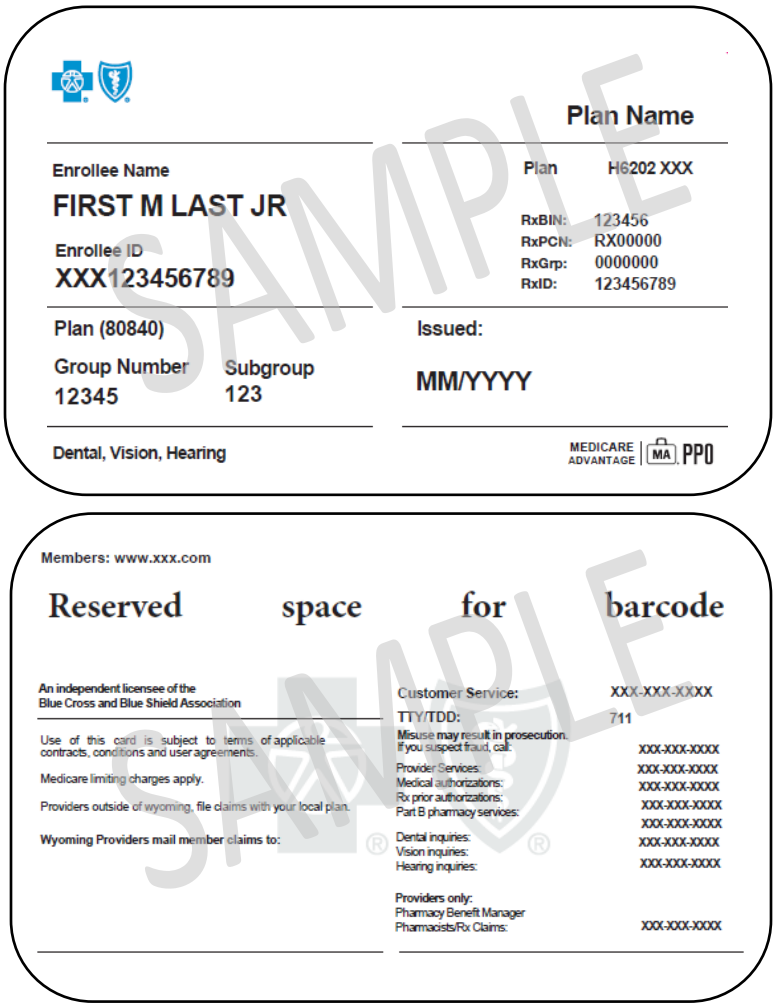
ID cards

Our patient identification cards contain basic information you will need when providing covered services to our patients. The WyoBlue Advantage ID card indicates that the patient is enrolled in a Medicare Advantage plan. Our WyoBlue Advantage patients only need to show their ID card to receive services. A patient does not need to show his/her Original Medicare ID card.

All Blue Cross and Blue Shield Association (the national organization for all BCBS plans) Medicare Advantage cards have a similar look and feel to promote nationwide ease of use. The cards include a magnetic stripe on the back to provide easier access to eligibility and benefit information.

You must include the three-character alpha prefix found on the patient's ID card when submitting paper and electronic claims. The alpha prefix helps facilitate prompt payment and is used to identify and correctly route claims and confirm patient coverage. It's critical for the electronic

routing of specific transactions to the appropriate WyoBlue Advantage plan.



The “MA” in the suitcase indicates a patient who is covered under the Blue Cross and Blue Shield network sharing program. The sharing program relates to affiliated or contracted Blue Cross providers and allows Medicare Advantage patients to obtain in-network benefits when traveling or obtaining services in areas outside of the Medicare Advantage plan. Patients with WyoBlue Advantage coverage should present their ID cards when requesting services from you.

The front of the card may include:

- The enrollee’s name, also called the subscriber or patient, who is the contract holder
- The enrollee ID (also called the contract number), which is made up of randomly chosen characters, either alpha-numeric or all numeric

- The issuer ID number just below the patient information. This number identifies which BCBS plan issued the card.
- A logo in the lower right corner of many cards that identifies the patient's prescription drug claims processor (for use by pharmacists)
- The group number
- Our website addresses
- Phone numbers
- An address showing where to send claims

Availity Essentials

Availity Essentials Provider Portal Resources

WyoBlue Advantage uses a self-service portal called Availity Essentials. Availity Essentials is a one-stop, secure provider portal where providers can easily submit and manage claims through the Electronic Data Interchange (EDI) system.

Availity Essentials is compliant with all HIPAA regulations, and there is no cost for providers to register or use any of the online tools.

Availity Essentials Functionality

- Submit eligibility and benefits inquiries for WyoBlue Advantage members
- Submit claims and review statuses
- Correct and void claims
- Request authorizations for precertification
- This process is completed through Symphony and will require staff training. Review WyoBlue Advantage's Prior Authorization Provider Portal Training – wyoblueadvantage.com/provider-resources
- View electronic remittance advices

Provider Availity Essentials Administrators will need to sign up for the WyoBlue Advantage payer ID WYBA within Availity Essentials to access certain criteria and functionality within the portal. The ERA/EFT sign up can only be completed by the Availity Essentials assigned administrator/administrator assistant.

If you do not have access to something within the Availity Essentials system, please contact your system administrator.

Learn more information on how to register by reviewing the Availity Essentials getting started course at apps.availity.com/availity/Demos/LP_AP_GetStarted/index.html#/. For

more information on how to register, and the variety of tools that are available to you, contact Availity Essentials.

Questions about Availity Essentials?

Contact Availity Essentials Client Services:

- Call: 1-800-282-4548
- 7 a.m. to 7 p.m. Central time, Monday through Friday
- www.availity.com

Eligibility and coverage

Check patient coverage at each visit

Each time your patient receives care, check to see if there have been any coverage changes.

Ask to see the patient's WyoBlue Advantage ID card or acknowledgement letter at every encounter.

Verify eligibility and coverage:

- Call 1-844-682-9449
- Use the online provider portal at Availity

Verifying eligibility and coverage for out-of-area members

To determine eligibility and cost-sharing amounts for Medicare Advantage Blue Cross patients from other states who use WyoBlue Advantage providers, call 1-844-682-9449 or go to www.bcbs.com and provide the patient's three-digit alpha prefix located on the ID card.

Billing patients

Collect copayments at time of service

You should collect the applicable copayments, also known as the patient's cost share, from your patient at the time of the service when possible. After collecting these amounts, bill WyoBlue Advantage or your local BCBS plan, if you provided services to out-of-state BCBS patients.

Balance billing is not allowed

You may only collect applicable cost shares from WyoBlue Advantage patients for covered services and may not otherwise charge or bill them.

Refund over-billed patients

If you collect more from a patient than the applicable cost share, you must refund the difference. Medicare Advantage patients are to be reimbursed within 30 days of recognizing the error.

Coordination of benefits

If a patient has primary coverage with another plan, submit a claim for payment to that plan first. The amount we pay depends on the amount paid by the primary plan. We follow all Medicare secondary payer laws.

Non-covered services and referrals for non-covered services — provider responsibilities

Sometimes you and your patient may decide that a service, treatment, or item is the best course of care, even though it's not covered by WyoBlue Advantage plans. This may be supplied by you or by another provider.

You are responsible for determining which services, treatments, or items are covered. If you believe that a service, treatment, or item will not be covered, you must tell the patient before the service is provided. If the patient acknowledges that the service, treatment, or item will not be covered by WyoBlue Advantage and would like to pursue the non-covered course of treatment, then you would need to submit a pre-service organization determination, also known as an advanced coverage determination.

If you provide a service, treatment, or item that is not covered, and you have not provided the patient with prior notice that the service, treatment, or item is not (or may not be) covered by the plan, you may not bill the patient for this service, treatment, or item.

If you believe that a service, treatment, or item will not be covered and you refer the patient to a provider who is not contracted with WyoBlue Advantage, you must tell the patient before you refer them. If the patient acknowledges that:

1. The service, treatment, or item will not be covered, and
2. Understands that you are referring them to a non-contracted provider, and
3. The patient agrees that he or she will be solely responsible for paying for the service, then
4. You or the rendering provider must obtain an advance coverage determination before the service or item is provided.

The process for requesting an advance coverage determination is explained below.

Provider request for an advance coverage determination

Getting an advance coverage determination (unrelated to services or items requiring prior authorization/ pre-certification)

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before providing a service or item.

All WyoBlue Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets Original Medicare medical necessity criteria, it will be covered by the plan.

Claims must meet eligibility and benefit guidelines to be paid.

To request an advance coverage determination, submit your request via fax to:

Wyoming providers
WyoBlue Advantage Utilization Management 855-933-2664

WyoBlue Advantage will decide and notify you within 7 days of receiving the request, with a possible 14-day extension either due to the patient's request or a WyoBlue Advantage justification that the delay is in the patient's best interest.

In cases where you believe that waiting for a decision under this time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, fax your request indicating "Urgent" or "Expedite" on the first page of the request. We will notify you of our decision within 72 hours; unless the patient requests a 14-day extension, or the plan determines that a 14-day extension is in the best interest of the patient.

Be sure to include the following information with your request for an advance coverage determination:

- Provider or supplier contact information, including name and address
- Anticipated date of service, if applicable
- Procedure/HCPCS and diagnosis codes
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were provided, and physician specialty
- Documentation and any correspondence that supports your position that the plan should cover the service or item, including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation
- Name and signature of the provider or provider's representative

Durable medical equipment, prosthetics and orthotics, medical suppliers, and pharmacists

DME Benefits

WyoBlue Advantage plans provide medically necessary durable medical equipment (DME), prosthetics and orthotics, medical supplies, and pharmacy; including Part B drugs, that are covered under Original Medicare.

For DME items totaling more than $1,000 per claim, a clinical review is required, as outlined in the "Clinician review of inpatient/outpatient services, select Part B medications, and DME" section of this manual.

Lab Services

WyoBlue Advantage network of labs

WyoBlue Advantage Medicare Advantage plans also include lab services and test specimens provided by participating hospitals and providers.

Benefits

Medical

For WyoBlue Advantage PPO patients Medicare Advantage benefits are available both in-network and out-of-network using BCBSA

network sharing providers outside of Wyoming, but within the USA. For basic Medicare benefits, refer to www.cms.gov.

Vision

WyoBlue Advantage PPO plans offer routine vision exam coverage administered by VSP. For information about VSP call 1-844-682-9966.

Telehealth (online visits)

WyoBlue Advantage patients have an Online Visit benefit. Patients may utilize Teladoc Health® for non-urgent medical and behavioral health concerns. To access this benefit, patients should visit: www.TeladocHealth.com.

Patients are encouraged to share a visit summary with their provider(s). If you would like to offer telehealth services and have the technology to do so, you may bill WyoBlue Advantage for these services as permissible within current CMS guidance.

Prior authorization

Some benefits require medical management. Therefore, prior authorization (PA) may be required for the following services:

- Inpatient Hospital - Acute
- Additional Days for Inpatient Hospital-Acute
- Inpatient Hospital Psychiatric
- Skilled Nursing Facility (SNF)
- Partial Hospitalization Programs
- Intensive Outpatient Program Services
- Home Health Services
- Opioid Treatment Program Services
- Diagnostic Procedures/Tests
- Lab Services
- Diagnostic Radiological Services
- Therapeutic Radiological Services
- Outpatient Hospital Services
- Observation Services
- Ambulatory Surgical Center (ASC) Services
- Air Ambulance Services
- Durable Medical Equipment (DME)
- Prosthetic Devices
- Medical Supplies
- Medicare Part B Chemotherapy/Radiation Drugs
- Other Medicare Part B Drugs

For additional benefit information, please contact Provider Services at 1-844-682-9449 or visit wyoblueadvantage.com/provider-

resources or use the Provider Portal to view patients' eligibility and claims status.

Primary Care Physicians (PCP)

Provider specialties recognized as PCPs

WyoBlue Advantage PCPs may specialize in the following:

- Family practice
- General practice
- Geriatrician
- Internal medicine

Hospice services

Claim submissions to Medicare contractors

Federal regulations require that Medicare fee-for-service contractors (Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier) maintain payment responsibility for WyoBlue Advantage patients who elect hospice care. Claims for services provided to a WyoBlue Advantage patient who has elected hospice care should be billed to the appropriate Medicare contractor.

- If the patient elects hospice care and the service is related to the patient's terminal condition, submit the claim to the regional home health intermediary.
- If the patient elects hospice care and the service is not related to the patient's terminal condition, submit the claim to the Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier as appropriate.
- If the service is provided during a lapse in hospice coverage, submit the claim to the local BCBS plan.
- If the service is not covered under Original Medicare but is offered as an enhanced benefit under the patient's Medicare Advantage (for example, vision or dental), submit the claim to the local BCBS plan or it's appropriate coverage administrator (vision, dental, etc.).

Medicare Advantage patient cost-

As provided in 42 CFR § 422.320, a Medicare Advantage Organization (MAO) must inform each enrollee eligible to select hospice care about the availability of hospice care if: (1) a Medicare

share for hospice services

hospice program is located within the plan's service area; or (2) It's common practice to refer patients to hospice programs outside the MAO's service area.

An MA enrollee who elects hospice care but chooses not to disenroll from the plan is entitled to continue to receive (through the MA plan) any MA benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the enrollee and WyoBlue Advantage will continue to pay providers and suppliers for other Medicare-covered services furnished to the enrollee.

The table below summarizes the cost sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

Type of services	Enrollee coverage choice	Enrollee cost sharing	Payments to providers
Hospice program	Hospice program	Original Medicare cost sharing	Original Medicare
Non-hospice[1], Parts A & B	MA plan or Original Medicare	MA plan cost-sharing if enrollee follows MA plan rules[3]	Original Medicare[2]
		Original Medicare cost-sharing if enrollee does not follow MA plan rules[3]	Original Medicare
Non-hospice[1], Part D	MA plan (if applicable)	MA plan cost sharing	MAO
Supplemental	MA plan	MA plan cost sharing	MAO

Notes: [1]The term "hospice care" refers to Original Medicare items and services related to the terminal illness for which the WyoBlue Advantage patient entered the hospice. The term "non-hospice care" refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

[2]If the WyoBlue Advantage patient chooses to go to Original Medicare for non-hospice, Original Medicare services, and agrees to follow WyoBlue Advantage's requirements, then, as indicated, the WyoBlue Advantage patient pays WyoBlue Advantage's cost-sharing

amounts and Original Medicare pays you. The MA plan must pay you the difference between Original Medicare cost sharing and plan cost sharing, if applicable.

[3]A WyoBlue Advantage patient who receives services out-of-network and has followed plan rules is only responsible for plan cost sharing. The WyoBlue Advantage patient doesn't have to communicate to WyoBlue Advantage in advance regarding his/her choice of where services are obtained.

Access to care

After-hours access

CMS requires that the hours of operation of its providers are convenient for and do not discriminate against patients.

As a practitioner, you must provide coverage for your practice 24 hours a day, seven days a week with a published after-hours telephone number (to your home or other relevant location); pager or answering service; or a recorded message directing patient to another provider for after-hours care instruction.

Note: Recorded messages instructing patients to obtain treatment via emergency room for conditions that are not life threatening is not acceptable. In addition, primary care physicians must provide appropriate backup for absences.

Appointment access

As a practitioner, you must, at a minimum, meet the following appointment standards for all WyoBlue Advantage patients. Appointment accessibility will be measured and monitored using the following standards:

- Preventive care appointment (routine primary and specialty care) — service is provided within 30 business days.
- Routine care appointment (follow-up, non-urgent, symptomatic) — service is provided within 5 business days.
- Urgent medical care appointment (acute, symptomatic) — service is provided within 24 hours.

Compliance with access standards

If it's determined that you do not meet access to care standards, then you must submit a corrective action plan within 30 days of notification.

If…	Then…
The corrective action plan is approved	You are notified, and your office will be called approximately **14 days** after receipt of the corrective action plan to reassess compliance with the corrective action plan.
The corrective action plan is not approved	A request will be made that you submit an acceptable corrective action plan within **14 days**.
A reply is not received within **14 days**	You will be sent a second letter, signed by the appropriate medical director. Copies of the letter will be forwarded to the WyoBlue Advantage Quality Improvement Department.
A reply to the second letter is not received within **14 days**	A third letter, signed by an appropriate medical director, will be sent to inform you that termination will occur within **60 days**.

WyoBlue Advantage encourages you (or your office staff) to assist patients, whenever possible, in finding an in-network provider who can provide necessary services. If assistance is needed in arranging specialty care (in- or out-of-network), please call our Provider Services department at 1-844-682-9449.

WyoBlue Advantage network providers must ensure that all services, both clinical and non-clinical, are accessible to all patients and are provided in a culturally competent manner, including to those patients with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. You and your office staff are not allowed to discriminate against patients in the delivery of health care services consistent with benefits covered in the patient's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as end-stage renal disease, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. It's necessary that your office can demonstrate that you accept any patient in need of health care treatment you provide.

Advance directives

Necessary documentation

WyoBlue Advantage plans provide information to patients on their right to complete an advance directive. Advance directive means a written instruction, recognized under state law, relating to how to provide health care when an individual is incapacitated. As part of the medical record content requirements for WyoBlue Advantage, you must document in the medical record whether a patient has or does not have an advance directive. If a patient has completed and presents an advance directive, then you must include it in your patient's medical record.

Quality Improvement (QI)

WyoBlue Advantage QI programs

WyoBlue Advantage is committed to improving the quality of health care for our patients. WyoBlue Advantage maintains a quality improvement program that continuously reviews and identifies the quality of clinical care and services patients receive and routinely measures the results to ensure patients are satisfied and expectations are met.

The WyoBlue Advantage QI unit develops an annual quality improvement program that includes specific quality improvement initiatives and measurable objectives. Activities that are monitored for QI opportunities include:

- Appointment and after-hours access monitoring
- Quality of care concerns
- Patient satisfaction
- Chronic care management
- Utilization management
- Health outcomes
- Medical record documentation compliance
- Quality improvement projects
- Healthcare Effectiveness Data and Information Set (HEDIS*)
- Consumer Assessment of Healthcare Provider and Systems Survey and Health Outcomes Survey
- Regulatory compliance

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS

HEDIS is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. WyoBlue Advantage follows HEDIS reporting requirements established by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services. Audited HEDIS reports are used to identify quality improvement opportunities and develop quality related initiatives.

The HEDIS measures that WyoBlue Advantage focuses on include (but are not limited to):

- Acute hospital utilization
- Adherence to antipsychotic medication for individuals with schizophrenia
- Adults access to preventive/ambulatory health services
- Adult body mass index assessment (document weight, height, and BMI value in the medical record)
- Adult immunization status
- Ambulatory care (outpatient visits and emergency department visits)
- Alcohol and other drug dependence treatment — initiation and engagement
- Antibiotic utilization
- Asthma Medication Ratio
- Breast cancer screening (women 50 to 74 years of age)
- Board certification
- Colorectal cancer screening (patients 50 to 75 years of age)
- Comprehensive diabetes care
- Blood pressure control <140/90
- Depression screening
- Dilated retinal eye examination
- Glycemic status assessment for patients with diabetes
- Medical attention for nephropathy
- Controlling high blood pressure
- Confirmed diagnosis of hypertension (documented in the medical record prior to June 30)
- Adequate control of hypertension <140/90 (patients 18 to 59 years of age)
- Adequate control of hypertension <140/90 (patients 60 to 85 years of age with diagnosis of diabetes)
- Adequate control of hypertension <150/90 (patients 60 to 85 years of age without a diagnosis of diabetes)
- Disease-modifying anti-rheumatic drug therapy in rheumatoid arthritis
- Emergency department utilization
- Fall risk management

- Follow up after emergency department visit for alcohol and other drug dependence (within seven to 30 days)
- Follow up after emergency department visit for mental illness (within seven to 30 days)
- Follow up after hospitalization for mental illness (within seven to 30 days)
- Frequency of selected procedures
- Hospitalization for potentially preventable complications
- Identification of alcohol and other drug services
- Inpatient utilization — general hospital/acute care
- Management of urinary incontinence in older adults
- Medication management for people with asthma
- Medication reconciliation post-discharge
- Mental health utilization
- Non-recommended prostate-specific-antigen based screening in older men
- Osteoporosis testing in older women
- Osteoporosis management in women who have had a fracture (women 67 to 85 years old)
- Persistence of beta-blocker treatment after a heart attack
- Pharmacotherapy for opioid use disorder
- Pharmacotherapy management of chronic obstructive pulmonary disease (COPD) exacerbation
- Systemic corticosteroid
- Bronchodilator
- Physical activity in older adults
- Plan all-cause re-admissions
- Potentially harmful drug-disease interactions in the elderly
- Social need screening and intervention
- Standardized health care-associated infection ratio
- Statin therapy for patients with cardiovascular disease
- Statin therapy for patients with diabetes
- Tobacco cessation — medical assistance
- Use of high-risk medications in the elderly
- Use of opioids at high dosage
- Use of opioids from multiple providers

What is the CMS Quality Star Rating program?

CMS evaluates Medicare Advantage health insurance plans and issues Star ratings each year; these ratings may change from year to year. The methodology used by CMS is subject to change; final guidelines are released each spring after the measurement year. The CMS plan rating uses quality measurements widely recognized within the health care and health insurance industries to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services that the WyoBlue Advantage plans offer. CMS

compiles its overall score for quality of services based on measures such as:

- How WyoBlue Advantage helps patients stay healthy through preventive screenings, tests, and vaccines, and how often they receive preventive services to help them stay healthy
- How WyoBlue Advantage helps patients manage chronic conditions
- Patient satisfaction with WyoBlue Advantage and their experience with their provider
- How often patients filed a complaint against WyoBlue Advantage
- How well WyoBlue Advantage handles calls from patients

In addition, because WyoBlue Advantage plans offer prescription drug coverage, CMS also evaluates these prescription drug plans for the quality of services covered such as:

- Medication adherence and medication therapy management
- Drug plan customer service
- Drug plan patient complaints and Medicare audit findings
- Patient experience with drug plan
- Drug pricing and patient safety

How are Star Ratings derived?

Star measurement is comprised of approximately 40 measures and is assessed across clinical, patient perception, and operational measures. The methodology used by CMS is subject to change and final guidelines are typically published each spring after the measurement year. Performance is converted to Star Ratings, based on CMS specifications, as one through five stars, where five stars indicate higher performance.

This rating system applies to all Medicare Advantage lines of business: health maintenance organizations, preferred provider organizations and prescription drug plans. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov to help beneficiaries choose a Medicare Advantage plan offered in their area.

Star HEDIS performance

HEDIS performance is determined by who, in the eligible population, received appropriate services as defined by the measure.

- Numerator: Eligible population that met the criteria
- Denominator: Eligible population for the measure

CMS determines the thresholds of performance required to achieve a Star Rating after the measurement year has ended and all performance data has been collected.

Classification of HEDIS measures

Administrative: Transaction data or other administrative data are used to identify the eligible population and the numerator. The reported rate is based on all patients who meet the eligible population and who are found through administrative data to have received the service required.

Hybrid: Administrative data is used to identify the eligible population. A combination of administrative data and medical record review data is used to calculate the numerator.

WyoBlue Advantage's Star goals

WyoBlue Advantage is strongly committed to providing high-quality health plans that meet or exceed all CMS quality benchmarks. WyoBlue Advantage works with you and your patients to ensure that:

- Patients receive appropriate and timely care
- Chronic conditions are well-managed
- Patients are pleased with the level of service from their health plan and care providers
- Health plans follow CMS operational and marketing requirements

WyoBlue Advantage uses multiple techniques, including mailings and personal and automated phone calls, to remind patients about needed care and to help maintain optimal health. We also partner with you by identifying your WyoBlue Advantage patients who need specific medical services so that you can contact those patients and schedule necessary services.

Provider tips for improving Star Ratings and quality care

WyoBlue Advantage quality goals:

- Continue to encourage patients to obtain preventive screenings annually or when recommended
- Create office practices to identify noncompliant patients at the time of their appointments
- Submit complete and correct encounters/claims with appropriate codes
- Understand the metrics included in the CMS rating system
- Review the gap-in-care files listing patients with open gaps
- Ensure documentation includes assessment of cognitive and functional status

To learn more about:

- Star Quality Rating System, visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS

- HOS, visit www.hosonline.org/en/survey-instrument
- CAHPS survey, visit www.ahrq.gov/cahps/index.html
- HEDIS, visit www.ncqa.org/hedishttp://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx*

HEDIS medical record reviews

Reviews

WyoBlue Advantage captures medical data for HEDIS at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archivedmedical records/data may be required to complete data collection.

For HEDIS reviews, we look for details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results, colorectal cancer screenings and body mass index. This information helps us enhance our patient quality improvement initiatives.

WyoBlue Advantage employees or designated vendor(s) perform HEDIS reviews. Provider offices are responsible for responding to the medical record request, and for providing the documentation requested in a timely manner. WyoBlue Advantage or its designated vendor(s) will contact your office to establish a date for an onsite visit or the option to fax or mail the data requested. A patient list will be sent including the name and information being requested. If your office is selected for an onsite visit, please have the medical records available in advance of the visit. If a chart for a patient is being requested and not available at your practice location, please notify the WyoBlue Advantage employee or the designated vendor immediately.

We request that you allow WyoBlue Advantage employees or its designated vendor(s) to scan the medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record. WyoBlue Advantage will not reimburse for copy house services. If a provider or an accountable care organization contract with a copy house vendor, they will be responsible for reimbursing that vendor.

Health management services

Overview

The WyoBlue Advantage Health Management program promotes cost-effective and medically appropriate care and services. Components include, but are not limited to, clinical review of selected services and care management. This comprehensive approach employs key interactive activities across the care continuum.

Services

Health Management provides:

- Clinical review of inpatient, select outpatient, and select Part B medications
- 24/7 on-call nurse availability for urgent after-hours requests
- Coordination of care after patient is discharged from an acute care facility
- Identification of patients for care management program referrals
- Quality of Care (QOC) services
- Document Chronic Care Improvement Plan (CCIP) goals and annual updates

Telephonic health care

Telephonic nurses will provide outreach to patients. Case Managers and Care Transition (CT) nurses are available during normal business hours weekdays from 8 a.m. to 5 p.m. local time at the following number:

- Phone: 1-800-638-4304

Contact information during normal business hours

You may submit prior authorization requests via:

- Online provider portal: Availity
- Phone: 1-844-602-2570
- Fax for acute admissions, SNF, LTACH, Inpatient rehabilitation, and DME: 1-855-933-2664
- Fax for Part B medications: 1-XXX-XXX-XXXX. *Faxed request can be sent 24 hours a day, seven days a week, however they will only be processed during normal business hours weekdays from 8 a.m. to 5 p.m. local time. Please use our after-hour phone for urgent requests.*
- <Placeholder for additional ways to submit Pharmacy and Medical Prior Auth>

After-hours contact information for UM

Utilization Management (UM) staff are available after normal weekday business hours (8 a.m. to 5 p.m. local time) and on weekends and holidays, with 24-hour service to assist physicians and other providers with urgent authorization requests.

Providers should call 1-844-602-2570 and follow the prompts to reach a Utilization Review Nurse for any of the following needs:

- Determining alternatives to inpatient admissions and triaging patients to alternate care settings
- Arranging for emergent home health care, home infusion services and in-home pain control
- Arranging for durable medical equipment
- Coordinating and obtaining authorization for emergent discharge plans
- Expediting appeals of UM decisions

Note: Precertification for admission to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergent placement.

Utilization Management (UM) program

Goals

The WyoBlue Advantage UM Program is designed to promote quality, cost-effective and medically appropriate services. The UM Program uses a comprehensive approach by integrating key medical UM activities. WyoBlue Advantage reviews and updates annually.

The primary goals of the program are to:

- Achieve effective, high-quality outcomes that meet the expectations of patients, purchasers, and clinical health care professionals, by ensuring that medically necessary care is delivered in the appropriate setting at the time such service is needed.
- Monitor effective and efficient medical and behavioral health utilization of services.
- Provide a comprehensive UM Program to monitor patient progress toward expected outcomes, resource use, and efficient and effective transitions across the continuum of care.

Medical records

Patient medical records and health information shall be maintained in accordance with current federal and state regulations, including prior consent when releasing any information contained in the medical record.

You must maintain timely and accurate medical records related to services you render to your patients. You shall maintain such records

and any related contracts for 10 years from date of service unless a longer time period is required by applicable statutes or regulations.

You shall give without limitation, WyoBlue Advantage, U.S. Department of Health and Human Services, U.S. General Accounting Office, or their designees, the right to audit, evaluate, and inspect all books, contracts, medical records, and patient care documentation, maintained by you, which will be consistent with all federal, state, and local laws. Such records will be used by CMS and WyoBlue Advantage to assess compliance with standards which include, but are not limited to:

- Complaints from patients and/or providers
- HEDIS® reviews, quality studies/audits or medical record review audits
- CMS and Medicare Advantage reviews of risk adjustment data
- WyoBlue Advantage determinations of whether services are covered under the plan are reasonable and medically necessary and whether the plan was billed correctly for the service
- Advance coverage determinations
- Medical Management specific medical record reviews
- Suspicion of fraud, waste and/or abuse
- Periodic office visits for contracting purposes; and
- Other reviews deemed appropriate and/or necessary.

Medical record content and requirements for all providers (for behavioral health providers, see below) include, but may not be limited to:

- Clinical record:
    - Patient name, identification number (name and ID number must be on each page), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.
- Medical documentation:
    - History of last physical exam, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services, and other risk screening.
    - Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:

- Past medical, surgical, and behavioral history (if applicable), chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age- and sex-specific risk screening exam, relevant review of systems (including depression and alcohol screening).
- Documentation of patient education (age and condition specific), if applicable injury prevention, appropriate dietary instructions, lifestyle factors and self-exams.

- Clinical record — progress notes:
  - Identification of all providers participating in the patient's care and information on services furnished by these providers.
  - Reason for visit or chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, how follow-up plans from previous visits have been addressed and follow-up report to referring provider, if applicable.
- Clinical record — reports content (all reviewed, signed, and dated within 30 days of service or event)
- Lab, X-ray, referrals, consultations, discharge summaries, consultations and summary reports from health care delivery organizations such as skilled nursing facilities, home health care, free-standing surgical centers, and urgent care centers. HEDIS is a registered trademark of the National Committee for Quality Assurance.

Clinician review of inpatient/outpatient services, select Part B medications, and DME

Inpatient services	The following services require clinical review: • Inpatient admissions • Skilled nursing facility admissions (SNF) • Long-term acute care hospital (LTACH) admissions • Inpatient rehabilitation admissions
Part B drugs (classes of drugs)	The following services require clinical review: • Inflammatory/autoimmune disorder • Ophthalmic injections • Enzyme replacement therapy

- Pulmonary/respiratory
- Non-cosmetic Botox and Botox-like agents
- Osteoporosis or bone modifiers
- Misc. biologic (hemolytic uremic syndrome, Duchenne muscular dystrophy treatment, Castleman's disease, hereditary transthyretin-mediated amyloidosis, clostridium difficile infection, X-linked hypophosphatemia)
- Free radical scavenger (amyotrophic lateral sclerosis)
- Immunoglobulin
- HIV
- Antisense oligonucleotide (spinal muscular atrophy)
- Recombinant enzyme (chronic gout)
- Hematopoietic agent
- Chemotherapy/oncology biologic

Not Otherwise Classified (NOC) codes

Certain NOC medications codes do not require a PA and will be reviewed as a post-service request. NOC codes are also referred to as "unclassified codes," "unlisted codes," and "unspecified codes."

Clinical service notification

You are advised to submit clinical information via fax, phone, or online for elective acute care admissions, care provided at SNF, LTACH, and inpatient rehabilitation facilities, and Part B medication requests prior to the start date. You are advised to submit clinical information via fax, phone, or online on the next business day for all urgent acute care admissions.

There are form templates, which identify the specific information required to process a service request.

If the nursing clinical review staff is unable to approve the request for inpatient services, the request is referred to a plan medical director for review.

When the plan medical director is unable to approve the service, a denial notification is sent to you and the patient. The denial notification includes:

- Description of the criteria utilized to render the determination
- Reason for the denial
- Right to request the criteria used to render the decision
- Right to request the diagnosis and procedure codes related to the request
- Description of how to file an appeal
- Availability of a plan medical director to discuss the individual merits of the case

Pharmacists review and make final determinations on all requests for Part B Medications that require PA.

The clinical staff also reviews requests that require a benefit determination. If the service is not a covered benefit, the clinical staff denies the request. The denial notification includes the specific location in the *Evidence of Coverage* that describes the exclusion as well as the patient's appeal rights.

All decisions are made and notifications are provided in compliance with state and federal laws, regulations, and accreditation standards. A plan medical director makes all denial determinations based on medical necessity.

Application of medical necessity criteria

Overview

Clinical staff applies objective and evidence-based criteria for medical services that require medical necessity review. All clinical staff must retain a current unrestricted license. Clinical managers provide oversight of the clinical staff who review services that require the application of medical necessity criteria. The patient's individual circumstances and the Wyoming delivery system are considered when determining appropriateness of services. Written policies and procedures provide the staff with direction for appropriately applying the criteria. Clinicians base utilization decisions about care and service solely on the appropriateness related to each patient's specific condition. Clinical review staff has no compensatory arrangements that encourage denial of coverage. Plan medical directors and/or pharmacists render all denial determinations based on medical necessity.

Monitoring utilization

WyoBlue Advantage uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure that WyoBlue Advantage patients receive the medical services required for health promotion, including acute and post-acute care management. Some examples of these mechanisms include:

- Results of patient satisfaction surveys
- Rate of inpatient admissions
- Rate of emergency services
- Review of alternative levels of care such as observation

Process for approvals and decisions

WyoBlue Advantage continues to demonstrate its commitment to a fair and thorough utilization decision process by working collaboratively with its participating physicians. A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by WyoBlue Advantage Health Management nurses. It may be necessary for the plan medical director to contact physicians for additional information about their patients to assist in making a determination.

Clinical review requirement

The WyoBlue Advantage clinical review process is established to do the following:

- Ensure uniformity in the provision of medical care
- Ensure the medical appropriateness and cost-effectiveness of certain services
- Improve the overall quality of care WyoBlue Advantage patients receive
- Lower the cost of coverage for WyoBlue Advantage patients

Inter-Rater reliability

Overview

The UM department ensures the consistency with which the clinical staff applies medical necessity criteria by performing inter-rater audits at least annually. Consistent application of medical necessity criteria reduces the potential for waste of health care services. The goal for staff in their role for one year or greater is an aggregate annual score of at least 90 percent. The goal for staff functioning in their role for less than one year is an aggregate annual score of at least 85 percent. Staff who do not achieve the required aggregate score are provided improvement plans and re-audited after the interventions are completed.

UM management decision and notification timeliness

Overview

The UM department is committed to performing decision and notification activities in a consistent and timely manner to minimize disruption in the provision of health care for its patients. WyoBlue Advantage makes timely UM decisions and provides notification to

you and your patient according to the clinical urgency of the service request. UM decisions are made in compliance with state, federal and accrediting agency regulations. Leadership performs ongoing monitoring of adherence to established time frames.

Opportunities for improvement are conducted at the individual staff and department-wide levels.

Clinical review required specifics

WyoBlue Advantage must review and approve select services before they are provided. The primary reason for clinical review is to determine whether the service is medically necessary, whether it's performed in the appropriate setting and whether it's a benefit.

Criteria review required specifics

InterQual® criteria adopted by the plan are updated annually and include CMS Medicare Guidelines and the following:

Criteria	Applications
InterQual Acute — Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care — Subacute and Skilled Nursing Facility	Subacute and skilled nursing facility admissions
InterQual Rehabilitation — Adult	• Inpatient rehabilitation admissions • Continued stay and discharge readiness
InterQual Level of Care — Long-Term Acute Care	Long-term acute care facility admissions
InterQual Procedures — Adult	Surgery and invasive procedures

Medical policies	Part B Medications and 30-day bundling criteria
CMS Inpatient Procedure List	CMS list of procedures that can be performed in the inpatient setting: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS049493

Clinical review determination

To determine medical necessity, clinical information is necessary for all services that require clinical review. In addition to reviewing clinical information, WyoBlue Advantage Health Management evaluates:

- The patient's eligibility coverage and benefits
- The medical need for the service
- The appropriateness of the service and setting

If additional clinical information is required to approve the service, a WyoBlue Advantage UM representative telephones you or your office to ensure that all needed information is received in a timely manner. A written request may also be sent to you and your patient receiving the authorization.

Submitting required information with initial review request

You are encouraged to submit the required clinical information with the initial request for clinical review using the online Provider Portal <Placeholder link> or via fax below.

For clinical Information for Part B Medication PA, fax 1-XXX-XXX-XXXX

- For clinical information for Acute and Post-Acute Hospital Admissions, fax UM at 1-855-933-2664

WyoBlue Advantage is required by Medicare to notify patients of the clinical information needed to process a request for clinical review when the information is not provided at the time of the request. When you submit the clinical information with the initial request, it decreases the number of letters WyoBlue Advantage is required to send topatients.

Standard time frames for all requests for service

WyoBlue Advantage conducts timely reviews of all requests for service, according to the type of service requested. Decisions are made within the time frames (calendar days) below:

CMS regulatory timelines

Type of Request	Decisions	Initial Notifications	Written Notifications	Type of Services
Pre-service urgent/ concurrent [v]	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification	Acute and post-acute admissions
Pre-service nonurgent	Within 7 days of receipt of request	Within 7 days of receipt of request	Within 7 days of receipt of request	Medication and patients already admitted
Post-service	Within 7 days of receipt of request	N/A	Within 7 days of receipt of request	Services already provided

For Part B medications

Type of Request	Decisions	Initial Notifications	Written Notifications	Type of Services
Pre-service urgent [v]	Within 24 hours from receipt of request	Within 24 hours from receipt of request	Within 3 days of initial notification	Part B Medication
Pre-service non-urgent	Within 72 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request	Part B Medication

[v] Urgent pre-service urgent/concurrent means if you believe that waiting for a decision under the standard time frame could place your patient's life, health, or ability to regain maximum function is in serious jeopardy.

Notification of Decisions:

If…	Then…
The service is approved	For all service requests, your patients and you receive written notification. You will also receive verbal notification for inpatient and post-acute services.
The service is denied	WyoBlue Advantage UM sends your patient, you, and the facility a letter within the time frames stated above. The letter includes the reason(s) for the denial, informs your patient and you of their/your right to appeal and explains the appeals process. WyoBlue Advantage UM also notifies you of all denied determinations.

Guidelines for observations and acute inpatient hospital admissions

Contracted facilities must notify WyoBlue Advantage UM of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that patients receive care in the most appropriate setting, that WyoBlue Advantage Health Management is involved in the evaluation and coordination of discharge planning, and that there are appropriate referrals to Health Management for patients who need those services. Particular attention is given to patients with complex and chronic disease processes, demonstrated high use of health resources, and/or who are at high risk for health complications.

WyoBlue Advantage Utilization Management nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital's utilization review staff. When necessary to obtain information, Utilization Management nurses also speak to attending physicians.

Clinical information includes relevant information about the patient regarding:

- Health history

- Physical assessment
- Test and laboratory results
- Consultations
- Emergency room treatment and response
- Admitting orders

Note: A copy of the Prior Authorization Form used to submit clinical information for inpatient acute admissions can be found on the WyoBlue Advantage website: wyoblueadvantage.com/provider-resources This form also includes required documentation for readmissions within 30 days of discharge from the initial admission with the same or a similar diagnosis.

Once authorization is obtained, the facility will receive an authorization number that is valid for the entire length of stay for the acute-care admission.

Observation care

Observation care is a well-defined set of specific, clinically appropriate services that are described as follows:

- The services include ongoing short-term treatment, assessment, and reassessment.
- The services are furnished while a decision is being made regarding whether a patient requires further treatment as a hospital inpatient or can be discharged from the observation bed.

Observation stays of up to 48 hours for patients who may be eligible for reimbursement when you need more time to evaluate and assess a patient's needs in order to determine the appropriate level of care.

Examples (not all-inclusive) of diagnoses that may be treated in an observation setting include:

- Chest pain
- Syncope
- Cellulitis
- Pneumonia
- Bronchitis
- Pain or back pain
- Abdominal pain
- Pyelonephritis
- Dehydration (gastroenteritis)
- Overdose or alcohol intoxication
- Closed head injury without loss of consciousness

Requirements for observation stays	Observation stays do not require any PA or pre-notification requirements for patients.
Providing Medicare Outpatient Observation Notice (MOON)	WyoBlue Advantage follows CMS guidance for the Medicare Outpatient Observation Notice (MOON). Hospitals and Critical Access Hospitals (CAHs) are required to furnish the MOON to any Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. The MOON is a standardized notice developed to inform beneficiaries, including Medicare health plan enrollees, that they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release. The MOON notice informs beneficiaries of the reason(s) they are an outpatient receiving observation services and the implications of such status to Medicare cost sharing and coverage for post-hospitalization SNF services. Your compliance with this notification requirement is mandatory. The standard language for the MOON notice and instructions can be accessed at www.cms.gov/Medicare/Medicare-General-Information/BNI.
Options available beyond the observation period	For patients who require care beyond the observation period, the following options are available: • Contact WyoBlue Advantage Health Management to discuss alternate treatment options such as home care or home infusion therapy • Request an inpatient admission Note: If the patient is not discharged within the 48-hour observation stay limit covered by the plan, you should re-evaluate your patient's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.
Medical necessity considerations : inpatient vs.	When patients are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses.

observation stays

Here are some guidelines that clarify how WyoBlue Advantage determines medical necessity:

- WyoBlue Advantage uses InterQual criteria to make determinations of medical necessity for all patients.
- WyoBlue Advantage does not require physician certification of inpatient status to ensure that a patient's inpatient admission is reasonable and necessary.
- When the application of InterQual criteria results in a patient's inpatient admission being changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- WyoBlue Advantage SNF clinical review process takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures.

Review of readmissions

WyoBlue Advantage reviews inpatient readmissions that occur within 30 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs), when the patient has the same or a similar diagnosis for the readmission. WyoBlue Advantage reviews each readmission to determine whether it resulted from one or more of the following:

- Premature discharge or a continuity of care issue
- Lack of or inadequate discharge planning
- Planned readmission
- Surgical complications

Guidelines for submitting PA requests for skilled nursing; long-term, acute care; and inpatient rehabilitation facilities

Overview

Facilities must notify WyoBlue Advantage of all post-acute admissions and provide clinical information prior to the admission for initial requests and prior to the expiration of approved days for continued stay review requests. Timely notification helps ensure that patients receive care in the most appropriate setting, that WyoBlue Advantage Utilization Management is involved in the evaluation and coordination of discharge planning, and that there are appropriate referrals to case management for patients who are managing active disease

processes, demonstrating high use of health resources, or who are at high risk for health complications.

WyoBlue Advantage UM nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital's utilization review staff. When necessary to obtain information, UM nurses may also speak to attending physicians.

Clinical information includes relevant information about the patient, including:

- Health history
- Prior level of functioning
- Clinical assessment
- Therapy evaluations
- Admitting orders
- Discharge plans

A copy of the form used to submit clinical information for post-acute admissions is available at Provider Resources – WyoBlue Advantage

For post-acute admissions, if authorization is obtained, it will be valid for a defined length of time. If additional days are needed, a continued stay review will be required prior to the expiration of the initial approved days.

Decision criteria and guidelines

WyoBlue Advantage criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan, or a combination of both. Individual circumstances of a patient are considered when applying the criteria, as are characteristics of the local delivery system, such as:

- Availability of skilled nursing facilities, subacute care facilities or home care in the network to support the patient after discharge
- Patient's coverage of benefits for skilled nursing facilities, subacute care facilities or home care, where needed
- Ability of network hospital(s) to provide all recommended services within the established length of stay

Discharge planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Patient
- Family
- Primary care physician
- Specialist
- Hospital discharge planning staff

- Ancillary providers, as necessary

WyoBlue Advantage monitors all hospitalized patients to assess their readiness for discharge and assist with post-hospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. WyoBlue Advantage nurses work in conjunction with patients' primary care physicians to authorize and coordinate post-hospital needs, such as home health care, durable medical equipment, and skilled nursing placement. For these patients, providers should follow the processes described in the "Guidelines for care transition" section of this chapter.

Note: Acute care, SNF, LTACH, and inpatient rehabilitation facilities require preauthorization.

Requesting an expedited decision

Either you or your patient may request an expedited decision (can take up to 72 hours) if you believe that waiting for a standard decision (up to 7 calendar days) could or would do one of the following:

- Seriously harm the life or health of the patient
- Seriously compromise the ability of the patient to regain maximum function
- Subject the patient to severe pain that cannot be adequately managed with the care or treatment that is being requested
- WyoBlue Advantage relies on you to determine conditions that warrant expedited decisions.
- If you request an expedited decision, the decision is made according to pre-service urgent time frames.
- If your patient requests an expedited decision, WyoBlue Advantage calls you to determine whether your patient's medical condition requires a fast decision.
    - If you agree, WyoBlue Advantage decides to approve or deny the request according to preservice urgent time frames (see table found above under the subheading "Standard time frames for all requests for service").
    - If you disagree, WyoBlue Advantage decides according to standard time frames (see table found above under the subheading "Standard time frames for all requests for service") and notifies the patient of a decision not to make an expedited decision.
    - WyoBlue Advantage will not make an expedited decision about payment for care your patient has already received.

Expedited requests must be submitted by faxing 1-855-933-2664 or calling 1-844-602-2570 during normal weekday business hours: 8 a.m. to 5 p.m. Local time.

Expedited requests may be submitted after hours by calling 1-844-602-2570.

Medical necessity general considerations

CMS requires WyoBlue Advantage to provide coverage to enrollees for all Part A and Part B Original Medicare covered services. However, CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes for providers as Original Medicare does.

While WyoBlue Advantage does apply medical necessity criteria to determine coverage, the criteria do not have to be applied in the same manner as required under Original Medicare. Specifically:

- Benefits: Medicare Advantage plans must provide or pay for medically necessary covered items and services under Part A (for those entitled) and Part B.
- Access: Medicare Advantage enrollees must have access to all medically necessary Part A and Part B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under Original Medicare.
- Billing and payment: Medicare Advantage plans need not follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures if both contracted and non-contracted providers are paid accurately, in a timely manner and with an audit trail.

When determining medical necessity, both WyoBlue Advantage and Original Medicare coverage and payment are contingent upon all of the following conditions being met:

- Service is in a covered benefit category.
- Service is not specifically excluded from Medicare coverage by the Social Security Act.
- Item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body part, or is a covered preventive service.

Patients held harmless

In accordance with their affiliation agreement, you may not seek payment from patients for elective services that have not been

approved by WyoBlue Advantage unless your patient is informed in advance regarding his or her payment responsibility.

The circumstances in which patients are held harmless for denied covered services include, but are not limited to:

- Urgent/emergent admission denials
- Partial denial of a hospital stay
- Requests for elective services provided by contracted providers that require clinical review but were not forwarded to WyoBlue Advantage prior to the service being provided
- Denials issued for post-service requests for services provided by contracted providers when the information submitted is not substantiated in the medical record

Patients at risk

In certain instances, patients are held at financial risk for denied services. These instances occur when:

- The patient's contract was not in effect on the date of service.
- The patient refuses to leave an inpatient setting after the attending physician has discharged the patient.
- A denial has been issued for pre-certified services.
- Services are provided that are not a covered benefit under the patient's contract.

Medical records requests

Medical records may be requested to help us make decisions or to investigate potential quality concerns. The patient's contract allows WyoBlue Advantage to review all medical records. WyoBlue Advantage is not responsible for any cost associated with the production or retrieval of medical records. It's the financial responsibility of you and/or third-party vendor contracted with you to provide the requested records. WyoBlue Advantage must receive all records within 10 days of the request.

Appealing UM decisions

Providers who offer services to patients have the right to appeal any denial made by WyoBlue Advantage. The provider appeals process for patients, however, is governed by Medicare regulations.

Provider appeals for utilization management decisions should follow the descriptions outlined below. For all other appeals, please refer to the grievance and appeal section of this manual.

Appeal type	Description of appeal process
Preservice appeal request (contracted or non-contracted physician) For standard non-urgent appeal requests prior to the service being provided	A contracted physician who is providing treatment to a patient, upon notice to the patient, may request a standard first-level appeal on the patient's behalf without submitting an Appointment of Representative form or Waiver of Liability form. In any case, the patient can choose to appeal without involving the physician. WyoBlue Advantage Appeals & Grievances PO Box 21012 Eagan, MN 55121 Fax: 1-855-595-2683
Post-service request (contracted physician or another contracted provider) For denials of post-service requests for urgent/emergent inpatient admissions or bundled admissions only	The appeal is conducted according to the two-level appeal provider process described later in this document. Note: WyoBlue Advantage assumes that the physician or other provider is acting on his or her own behalf. Submission of an Appointment of Representative form is not required for these appeals. WyoBlue Advantage Appeals & Grievances PO Box 21012 Eagan, MN 55121 Fax: 1-855-595-2683

Reimbursement

Guidelines

WyoBlue Advantage reimburses network providers at the reimbursement level stated in your Medicare Advantage section of the provider agreement minus any patient required cost sharing, for all medically necessary services covered by the MA Plan. Providers should collect any applicable cost-share from their patients at the time of service or when possible. You will be paid the lesser of the allowed

amount or your charge, minus the patient's cost share. This represents payment in full. You are not allowed to balance bill patients for differences between the allowed amount and charges.

We will process and pay clean claims within 30 calendar days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest in accordance with the applicable CMS guidelines.

WyoBlue Advantage provides an *Evidence of Coverage* (EOC) to all patients following enrollment. This document provides general benefit information for patients by plan option. It also describes patient cost-sharing requirements that can be used by you to collect payment at the time the service is provided, rather than waiting for the claim to be processed and then billing your patient.

Original Medicare benefit coverage rules apply, except where noted. WyoBlue Advantage will not reimburse providers for services that are not covered under Original Medicare, unless such services are specifically listed as covered services under the patient's Medicare Advantage Plan.

WyoBlue Advantage must also comply with CMS' National Coverage Determinations (NCDs), general coverage guidelines included in Original Medicare manuals and instructions, and written coverage decisions of the local Medicare Administrative Contractor (MAC).

Follow all Original Medicare billing guidelines and be sure to include the following on all claims:

- Diagnosis code(s) to the highest level of specificity; when a sixth or seventh digit exists for a code, you must supply all applicable digits
- All diagnosis codes relevant to the patient's current medical history, even if they are informational
- Medicare Part B supplier number, National Provider Identifier (NPI) and federal tax identification number
- The patient's WyoBlue Advantage numbers, including the alpha prefix, found on the patient's ID card

For paper claims, the provider's name should be provided in Box 31 of the CMS-1500 (02/12) claim form.

National coding guidelines are accessible at https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2022-7-2022-508.pdf

Providers affiliated with the MA network agree to WyoBlue Advantage reimbursement policies outlined in the MA section of the provider agreement. These include but are not limited to:

- Accepting the applicable MA plans' agreement as payment in full for covered services, except for cost sharing, which is the patient's responsibility
- Billing WyoBlue Advantage, not the patient, for covered services
- Not billing patients for covered services that are required but did not receive pre-approval

Claim Filing

HCFA-1500 professional claims

The timely filing limit is one calendar year from date of service or discharge. Claims, including revisions or adjustments that are not filed by you prior to the claim filing limit, will be your liability.

WyoBlue Advantage accepts the revised CMS-1500 claim form (version 02/12). All claims must be submitted using this form. Follow WyoBlue Advantage billing requirements, use CPT/HCPCS codes and ICD-10 diagnosis codes to the highest level of specificity, include NPI numbers on all claims, and send claims to WyoBlue Advantage or your local BCBS plan (see claim submission information below).

Taxonomy codes are a required field on every claim submitted to WyoBlue Advantage. Claims that do not contain a valid taxonomy code will be automatically rejected and returned for correction. This includes the taxonomy code being required at the rendering level when a rendering provider is included on a claim.

When submitting a corrected claim, you are required to complete field 22 of the CMS-1500 claim form. You must enter 7 for Replacement of a prior claim or 8 for Void/Cancel of a prior claim in the Resubmission portion of the field (found on the left-hand side of the claim form). The original claim number must be supplied in the Original Reference Number portion of the field (found on the right-hand side of the claim form).

For more information on how to properly complete the new CMS-1500 (02/12) claim form, visit the National Uniform Claim Committee at NUCC.org, or Medicare Claims Processing Manual Chapter 26 (Completing and Processing) at Medicare Claims Processing Manual (cms.gov), or Medicare Claims Processing Manual Chapter 1 (General Billing Requirements) at Medicare Claims Processing Manual (cms.gov) or contact your provider relations consultant.

Where to submit a claim:

Claim Source	Contact Information	EDI Claim Submission
Claims from MA Network Providers for MA WyoBlue Advantage members	Phone: 1-844-682-9449 Fax: 1-855-595-2895 WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121	Submit through Availity Portal or clearinghouse. WyoBlue Advantage Payer ID=WYBA
Medical claims for non-WY BCBS MA members using WY in-network Blue Cross network sharing providers	Phone: 1-844-682-9449 Fax: 1-855-595-2895 WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121	Submit through Availity Portal or clearinghouse. WyoBlue Advantage Payer ID=WYBA
Medical claims for WyoBlue members using Blue Cross network sharing providers outside of WY	Phone: 1-844-682-9449 Submit to provider's home BCBS plan	Submit to provider's home BCBS plan
Medical claims submission from out-of-network providers in EY	Phone: 1-844-682-9449 Fax: 1-855-595-2895 WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121	Submit through Availity Portal or clearinghouse. WyoBlue Advantage Payer ID=WYBA

View your electronic remittance advice (ERA)

Receive claim acknowledgment (277CA) and claim payment/remittance advice (835) transactions through the Remittance Viewer option under the Claims & Payment section of Availity Essentials.

To sign up for ERA-Remittance Viewer:

- Log in to Availity Essentials
- Click on the Claims & Payments dropdown
- Select Transaction Enrollment
  - Note: The system will prompt you to authenticate
- Click Enroll
- Follow through the prompts to submit your request

For detailed instructions, see Availity Essentials help topics for Transaction Enrollment (requires login to Availity Essentials).

Once enrolled the access to the administrator should be granted immediately. The administrator can then grant access to other users within their facility accordingly.

To view a remittance advice:

- Log in to Availity Essentials
- Click on Claims & Payment
- Select Remittance Viewer
- Search and view your remittances accordingly

For detailed instructions, see Availity Essentials help topics for Remittance Viewer (requires login to Availity Essentials).

To sign up for EFT, you must have successfully enrolled for ERA. Information regarding ERA can be found above.

Electronic Funds Transfers (EFT)

To sign up for Electronic Funds Transfers (EFT), providers must have successfully enrolled for Electronic Remittance Advice reviewer (ERA) via our Provider Portal, Availity Essentials. Enrollment for access is assigned by the provider's Availity Essentials administrator.

Providers who participate in all our plans Commercial, Medicaid Expansion and/or WyoBlue Advantage Medicare Advantage, can only have one bank account on file at a time.

To get enrolled with EFT:

- Log in to Availity Essentials
- Click on the Claims & Payments dropdown
- Select Transaction Enrollment
- Click Enroll
- Follow through the prompts to submit your request
- When inputting the National Provider Identifier (NPI) number, ensure you are using the group NPI, not an individual practitioner's NPI

Providers can check EFT submission progress status at any time by accessing the Transaction Enrollment page within Availity Essentials. EFT applications can take up to 60 days to be reviewed and completed.

Once approved, providers will see the approved EFT status, with a note confirming the EFT effective date. Until that effective date begins, providers will receive paper checks in the mail.

Any reimbursement for claims submitted prior to the EFT effective date will arrive as paper checks.

Reimbursement for claims submitted after the EFT effective date will be sent payment electronically.

Questions about EFT?

For additional questions regarding enrolling for an EFT, contact Availity Essentials at 1-800-282-4548.

Quality Improvement Organization (QIO) Appeals

Administrative denials

The administrative determination appeal process affords you one level of appeal for coverage determinations related to administrative denials.

Administrative denials are determinations made by WyoBlue Advantage in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness.

WyoBlue Advantage can issue administrative denials without review by a plan medical director. An administrative denial is applied when there is provider noncompliance with supplying clinical information needed to render a decision for inpatient admission.

Appealing administrative denials

Administrative appeal requests must be submitted to WyoBlue Advantage within 45 calendar days of your receipt of the denial decision. Documentation must include a written appeal request along with the rationale and supporting documentation (if applicable) related to the denial, and any other information pertinent to the request. WyoBlue Advantage notifies you of the decision within 30 calendar days of receiving all necessary information.

Mail inpatient administrative denial appeal requests to:	WyoBlue Advantage Appeals & Grievances Attn: First-Level Appeals PO Box 21012 Eagan, MN 55121 Fax: 1-855-595-2683

The decision regarding the administrative determination appeal process is final. If the administrative denial is overturned but a denial determination is subsequently provided in accordance with criteria, you

are eligible to appeal through the clinical determination appeal process described on the previous page.

Quality Improvement Organization – Acentra

A Quality Improvement Organization (QIO) consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan like Medicare Advantage. The QIO for Wyoming is Acentra.

Contacting the QIO

Patients may request a QIO review from Acentra if they disagree with the decision to discharge them by an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency.

To appeal, patients may contact Acentra at:	Acentra 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317 Beneficiary Helpline: 1-888-317-0891 TTY: 771 Fax: 844-878-7921 www.acentraqio.com/

Patient rights to appeal hospital discharge

Patients who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe that coverage of their hospital stay is ending too soon.

Hospitals are required to notify all MA patients who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the standard CMS form twice — the first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the patient or of his or her representative and provide a copy of the form.

Note: A link to the notice “An Important Message from Medicare About Your Rights” is found at: www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

Medicare Advantage patients have the right to appeal to the QIO for immediate review when a hospital and WyoBlue Advantage, with physician concurrence, determine that inpatient care is no longer necessary.

Hospital discharge appeal process

If the Medicare Advantage patient is dissatisfied with the discharge plan:

1. A patient who chooses to exercise his or her right to an immediate review must submit a request to the QIO, following the instructions on the notice “An Important Message from Medicare About Your Rights.”
2. If WyoBlue Advantage is driving the discharge, the QIO notifies the health plan that the patient has requested an immediate review.
3. WyoBlue Advantage or the facility is responsible for delivering to the patient a “Detailed Notice of Discharge” as soon as possible, but no later than noon of the day after the QIO’s notification. The standardized notice includes a detailed explanation of the reason that services are either no longer reasonable or necessary or are otherwise no longer covered. The notice must be completed and submitted by the entity that determined that covered services are ending, whether it’s WyoBlue Advantage or the facility.
4. WyoBlue Advantage or the facility must supply any other information that the QIO needs to make its determination as soon as possible, but no later than the close of business on the day that WyoBlue Advantage notifies the facility of the request for information. This includes copies of both the “An Important Message from Medicare About Your Rights” notice and the “Detailed Notice of Discharge,” plus written records of any information provided by phone.
5. The QIO notifies WyoBlue Advantage, the patient, the hospital, and the physician of its determination within one calendar day of receiving the requested information.
6. WyoBlue Advantage continues to be responsible for paying the costs of the patient’s stay until noon of the calendar day following the day that the QIO notifies the patient of their coverage decision.
7. If the patient is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from WyoBlue Advantage.

Patient responsibilities related to hospital discharges

The chart below summarizes the effect on patient responsibilities of appeal decisions related to hospital discharges.

If…	Then…
The QIO agrees with the doctor's decision to end covered services	The patient is financially responsible for services on the date indicated on the "Notice of Medicare Non-Coverage."
The QIO disagrees with the doctor's decision to end covered services	WyoBlue Advantage will continue to cover the services.

QIO immediate review of SNF, CORF and HHA discharges

WyoBlue Advantage patients receiving skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services have special appeal rights that allow an expedited review if the patient disagrees with the decision to end covered services.

The Medicare form "Notice of Medicare Non-Coverage" (NOMNC) is delivered to WyoBlue Advantage patients by the providers of SNF, HHA, or CORF services in the following situations:

- When medical necessity criteria are no longer met and no additional days are authorized by WyoBlue Advantage or the facility/provider, or
- At least two days prior to a scheduled discharge date.

The NOMNC contains detailed instructions about how patients may request an immediate appeal directly to the QIO if they disagree with the decision to end services.

The Notice of Medicare Non-Coverage appeal process

Medicare regulations require you to deliver the standard NOMNC to all patients when covered services are ending, regardless of whether the patient agrees with the plan to end services:

- You deliver the NOMNC to patients at least two calendar days before coverage ends. If your patient is receiving home health agency services and the span of time between services exceeds two days, you may deliver the NOMNC at the next-to-last time that services are furnished.

- The form must be delivered regardless of whether your patient agrees with the plan to end services.

Special considerations related to delivery of the NOMNC:

- WyoBlue Advantage encourages you to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.
- If the expected duration of services is less than two days, you may deliver the NOMNC at the start of service. A patient who receives the NOMNC and agrees with the termination of services before the end of the two days may waive the right to request the continuation of services.
- If the patient is not mentally competent to receive the notice, you must deliver it to the patient's authorized representative.
- You request that the patient signs and dates the NOMNC, acknowledging receipt of his or her appeal rights. If the patient refuses to sign the form, the facility must record the date and time it was delivered to the patient.

You are expected to retain a signed copy of the NOMNC form with the patient's medical record. The patient is responsible for contacting the QIO by noon of the day before services end if he or she wishes to initiate an expedited review by following the detailed instructions on the form.

When the patient initiates an expedited review, the "Detailed Explanation of Non-Coverage" (DENC) is delivered to the patient by the close of business on the same day that the QIO is notified of the patient's request for appeal. The DENC provides specific, detailed information about why the patient's SNF, HHA or CORF services are ending.

Note: The DENC must be completed and submitted by the entity that determines that covered services are ending, whether it's WyoBlue Advantage or the SNF, HHA or CORF provider.

WyoBlue Advantage may request medical records or other pertinent clinical information from you to assist with the completion of this step within the short time frames mandated by CMS regulations.

A copy of the DENC is also sent to the QIO.

QIO usually completes the expedited review process within 48 hours and you, the patient, and WyoBlue Advantage are notified of the decision.

If the patient is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from WyoBlue Advantage.

Patient responsibilities when appealing SNF, CORF or HHA discharges

The chart below summarizes the effect on patient responsibilities of appeal decisions related to discharges from SNF, CORF or HHA services.

If…	Then…
The QIO agrees with the provider's decision to end covered services	The patient is financially responsible for services on the date indicated on the NOMNC.
The QIO disagrees with the provider's decision to end covered services	WyoBlue Advantage will continue to cover the services.

Other consider-ations in the Notice of Medicare Non-Coverage process

You should also be aware of the following when notifying a patient that his or her services are ending:

- Contracted facilities should be using the appropriate NOMNC forms. You should insert their name, address and phone number in the spaces provided at the top of the form.
- WyoBlue Advantage may issue a next review date when authorizing SNF services.
- The next review date does not mean WyoBlue Advantage is denying further coverage.
- You should submit an updated clinical review on the next review date.
- If upon review of the updated clinical information a denial is issued, WyoBlue Advantage will allow for two additional days for you to supply the patient with the NOMNC. The form should only be given to patients when:
    - SNF criteria are no longer met, and no further days are authorized by WyoBlue Advantage, or
    - Two days prior to a scheduled discharge date.
- If there is a change in the patient's condition after the NOMNC is issued, both WyoBlue Advantage and providers should consider the new clinical information. If coverage is extended and a new end date set, you should inform the patient that services will continue. You must then inform the patient of the new coverage

end date either through delivery of a new or amended NOMNC at least two days before services end.

Care Transitions

Overview

The WyoBlue Advantage Care Transition (CT) to Home Program is the coordination of care after a patient is discharged from an inpatient acute care facility. Proactive interventions begin when the patient is directly contacted by telephone prior to discharge and continues post discharge during a 34-day period. WyoBlue Advantage annually reviews and updates the CT program.

The goals of the CT program are to:

- Increase patient adherence to treatment plan through education
- Improve health outcomes and patient experience
- Encourage patient communication with their provider about their health conditions and treatment
- Assist in coordinating care after discharge including follow-up visits
- Provide information about community resources that may be helpful
- Decrease inappropriate inpatient admissions and emergency room visits

Care Transition to home process

The process should follow these steps:

1. The CT nurse will receive a notification from the UM nurse when a patient is admitted to the hospital for acute care.
2. To be proactive and ensure a safe and effective discharge, the CT nurse will attempt to contact the patient during the inpatient admission to discuss discharge needs and will also work with their discharge planner.
3. Once the patient is discharged, the CT nurse will contact the patient to provide education, address gaps in care and medication adherence issues, and coordinate services as needed.
4. The nurse will also assess the patient's risk for readmission and apply appropriate follow-up interventions.

Care Transition program outcomes

CT program trends are analyzed and opportunities for improvement are identified through CT and UM reports. The program will use targeted interventions to drive positive and healthy patient outcomes,

monitor ongoing progress, and refer patients to the case management program as appropriate.

WyoBlue Advantage Case Management Program

The WyoBlue Advantage Case Management (CM) Program is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet a patient's health needs and to promote quality and cost-effective interventions and outcomes across the continuum of care. A nurse will work with patients, their families, their doctor, and other health professionals to facilitate appropriate utilization of health care services, and to help patients reach their optimum level of wellness through education, support, and coordination of care. WyoBlue Advantage annually reviews and updates the CM program.

The primary goals of the Case Management Program are to:

- Reduce costs related to unplanned readmissions, optimize resource utilization, affect healthy outcomes and patient experience, and support efforts to track quality measures, including those used by the Medicare Star Rating System.
- Help patients manage complex and chronic health conditions.
- Decrease the burden of disease complications through referrals that may improve patient self-management and increase patient compliance with treatment plans designed to maximize quality of life and reduce risk of unnecessary utilization.

Case manager role

A Medical Management Case Manager facilitates the physician's plan of treatment and the provision of health care services as outlined in evidence-based clinical practice guidelines. The case manager contacts patients by phone to perform an assessment of the patient's health care status. Goals are identified and interventions are implemented to support the physician's treatment plan. The case manager provides personalized support and education on disease, nutrition, medication, and managed care processes, and identifies and facilitates access to benefits and resources available to prevent complications and progression of disease.

The case manager coordinates care with the treating physician and offers suggestions to providers for patient management. Timely communication with the treating provider is essential in the performance of case management activities. Ongoing communication occurs based on changes in the patient's condition or identified needs.

The case manager may contact the treating provider and talk with the plan medical director, as necessary, in the following circumstances:

- When there are significant changes in the patient's health status
- When intervention on the part of the treating provider is thought to be necessary
- When the patient uses emergency room services or is admitted for inpatient care
- To review the patient's progress at various intervals in the case management process
- To notify the treating provider that:
  - A patient who was participating in the case management program refuses further intervention even though goals are unmet
  - A patient has not complied with the recommended plan of care
  - A potential urgent or emergent situation has been identified related to a patient (for example, safety issues such as a patient self-reporting taking an unusually large dose of medication, or the case manager identifying a potential case of abuse or neglect)
- To obtain the health information necessary to ensure the highest quality of care

Patient identification

The Health Management program provides patient-focused, individualized case management for patients who meet trigger criteria, including (but are not limited to):

- Dealing with chronic or complex disease processes
- At high risk for health complications
- Demonstrating high use of health care resources
- Experiencing repeated inpatient care admissions
- Having gaps in medical care
- Having issues with medication compliance
- Having issues with taking medications as prescribed

Case management direct referral sources

Patients get referred to these programs by a variety of sources, such as:

- Customer Service
- Care Transition program
- Primary care physician
- Completion of health assessments
- UM inpatient admissions
- Caregiver referral
- Patient self-referral

What you can expect from

Case managers recognize your right to:

case management

- Know how to contact the person responsible for managing and communicating with your patients
- Obtain information about case management programs and staff with which your patients are involved, including staff qualifications
- Be informed about coordination of all case management activities, interventions, and treatment plans through reports from the case manager
- Be supported by the case manager in making decisions interactively with patients regarding patient health care needs
- Receive courteous and respectful treatment from the case management staff

Note: Case managers may receive requests for services specifically excluded from the patient's benefit package. They will not make exceptions to patient's covered benefits. In these situations, case managers inform the patient about alternative resources for continuing care and how to obtain care, as appropriate, when a service is not covered or when coverage ends.

Health risk assessments

A health assessment completed by the patient is encouraged as part of an annual wellness visit for MA patients, according to the Patient Protection and Affordable Care Act and CMS WyoBlue Advantage mails the form to the patient and asks that the patient complete it and return it to Scantron®, our vendor, for processing. Patients receive a response letter from WyoBlue Advantage outlining topics they should discuss with their physician.

You should also remind patients to bring a copy of their patient health assessment or the response letter to their annual wellness visit. The results of the patient's health assessment need to be available during the wellness visit so they can be considered when a care plan is created.

Quality management

All MAOs are required to have a Quality Improvement (QI) program as described in the Code of the Federal Regulations (CFR) at 42 CFR §422.152, "Quality improvement program." The requirements for the Prescription Drug Plan (PDP) Quality Assurance program are based on regulations as per 42 CFR § 423.153(c).

The primary goal of the WyoBlue Advantage's QI program is to effect sustained improvement in patient health outcomes. As provided under 42 CFR §422.152(c) and §422.152(d), WyoBlue Advantage's QI program must include at least one chronic care improvement program

(CCIP) for one chronic condition and a quality improvement project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

Disputes, Appeals and Resolutions

Before Services are Provided

Appealing Pre-Service Organization Determinations

Providers who provide services for WyoBlue Advantage members have the right to appeal on behalf of a Medicare Advantage member any adverse pre-service organization determination, such as a prior authorization denial or an advance coverage determination, made by WyoBlue's Health Management team that resulted in a pre-service denial or other limitation of covered healthcare services. The provider appeals process for Medicare Advantage members is governed by Medicare regulations.

A contracted or non-contracted provider who is providing treatment to a WyoBlue Advantage member may appeal pre-service organization determination decisions to WyoBlue on behalf of the member. Resolve pre-service denials by appeal before services are rendered, or prior to submitting a claim for services already rendered. In any case, the member can choose to appeal a decision as well.

Standard (non-urgent) pre-service organization determination appeal requests should be submitted in writing to:

WyoBlue Advantage
Appeals & Grievances
PO Box 21012
Eagan, MN 55121

Or faxed to: 1-855-595-2683

The table below outlines level one appeal processing timeframes for pre-service organization determination appeal requests.

Type of Request		Decision
Inpatient Admissions/ Concurrent Review	Pre-service (urgent)*/ concurrent	Within 72 hours from receipt of request
	Pre-service standard	Within 30 days of receipt of request

Part B Drugs	Pre-service (urgent)*/ concurrent	Within 72 hours from receipt of request
	Pre-service standard	Within 7 calendar days from receipt of request

*Urgent pre-service means that the provider believes waiting for a decision under the standard timeframe could place a WyoBlue Advantage member's life, health or ability to regain maximum function in serious jeopardy.

Note: A request for a peer-to-peer call is available as part of the pre-service appeal process. Submit the Provider Appeal Form located here:wyoblueadvantage.com/provider-resources or same information in similar format and supporting documentation, preferably via fax, and include some available dates and times for the peer-to-peer call. WyoBlue Advantage will review and, at the discretion of the Medical Director, will then reach out to the provider to set up a time for the peer-to-peer call.

If contracted providers disagree with the level one appeal decision, they should follow the steps outlined in the decision letter to submit a level two appeal request.

All non-contracted providers who receive a level one partially favorable or an adverse decision are forwarded to the Independent Review Entity (IRE) for a level two appeal. A party does not have to make a separate request for a level two appeal. The IRE sends written notification to all parties that the level two appeal request has been received. The IRE must adhere to the following timeframes for notifying all parties in writing of their decision on the respective pre-service case type:

Type of Request:	Processing Timeframe:
Standard	Items and Services: 30 days Part B Drugs: 7 days
Expedited	72 hours

After Services are Provided

Appealing Post-Service Claim Decisions

Contracted and non-contracted providers have appeal rights for WyoBlue claim decisions.

Calling Provider Inquiry Services at 1-844-682-9449 is the first step in addressing questions or concerns (e.g., asking questions to better understand processing of a claim). If the provider did not receive resolution to the issue or if further review is needed on the claim after

speaking with a representative, a two-level written appeals process is available to all providers, as described in the table below.

For a non-contracted provider to appeal a post-service decision on behalf of a WyoBlue Advantage member, the non-contracted provider must sign and submit a Waiver of Liability. The Waiver of Liability indicates that the non-contracted provider formally agrees to waive any right to payment from the member for the service in question regardless of the outcome of the provider's appeal. The Waiver of Liability can be found at www.cms.gov/medicare/appeals-grievances/managed-care.

Two Level Appeal Process Applicable to Post-Service Health Management and Care Management Claim Decisions		
Level One appeals	Provider Request Filing and Deadline	Level One appeal requests must be submitted to WyoBlue in writing within 65 calendar days of the date noted on the written denial notification. Level One appeal requests may be in writing and must include appropriate documentation to support the request or may be done verbally.
	Submission Information	Write to: WyoBlue Advantage Attn: Provider Appeals PO Box 21012 Eagan, MN 55121 Fax: 855-595-2683
	WyoBlue Response Time	WyoBlue notifies the provider of the decision within 60 calendar days of receiving all necessary information.
Level Two appeals	Provider Request Filing and Deadline	Contracted provider Level Two appeal requests must be submitted to WyoBlue in writing within 65 calendar days of the date noted on the Level One appeal decision notification. A copy of the Level One decision letter and appropriate documentation to support the provider's Level Two appeal request must be submitted. Additional information about appropriate documentation for this appeal request is included below the table.
	Note: Adverse Level One appeal decisions for non-contracted providers are automatically forwarded to the IRE for a Level Two review.	
	Submission Information	Write to: WyoBlue Advantage

Two Level Appeal Process Applicable to Post-Service Health Management and Care Management Claim Decisions		
		Attn: Provider Appeals P.O. Box 21012 Eagan, MN 55121 Fax: 855-595-2683
	WyoBlue Response Time	WyoBlue notifies the contracted provider of the decision within 60 calendar days of receiving all necessary information. For non-contracted providers, the IRE will provide their decision in writing to all applicable parties within 60 calendar days of receipt of the case.
	Note: WyoBlue's Level Two appeal decisions are always final and binding on the provider.	

Follow the level one appeal process to submit the required medical documentation for review for the below scenarios:

- Modifier -22 (Increased procedural services): When modifier 22 is billed on the claim, it indicates that additional work requiring the practitioner's technical skill involve significantly increased work, time, and complexity than when the procedure is normally performed. The procedure and/or service may be surgical or non-surgical. Reimbursement already accounts for the possibility that sometimes the procedure will be simpler and other times more difficult than normal. However, there are times when a procedure can be significantly more difficult.
- Not Otherwise Classified (NOC) or Not Otherwise Specified (NOS) Codes: Providers should always bill a defined code when one is available. If one is not available, bill medical services using an unlisted service (NOC or NOS code), and for drugs or biological products, bill NOC (J-codes), as well as submit National Drug Code (NDC), quantity billed in units field, and concise description of drug.

As noted above, the provider must submit appropriate documentation for Level One appeal requests when appealing post- service claim decisions regarding medical necessity, medical appropriateness and other health management/care management claim denials. Appropriate documentation for those appeal requests includes:

- Completed Appeal Form located here:

wyoblueadvantage.com/provider-resources or the same information in a similar format that includes:

  - Urgency
  - Provider or supplier contact information including name and address

- Member information
- Type of appeal
- Claim information
- Reason for dispute - a description of the specific issue

- Copy of the provider's submitted claim with disputed portion identified
- Documentation and any correspondence that supports the provider's position that the plan's denial was incorrect (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)

Payment Disputes

Provider payment disputes are disputes in which the provider believes that the payment amount made by the WyoBlue Advantage plan to providers differs from the payment amount specified in a participating provider's agreement with WyoBlue.

If a provider believes that the payment amount the provider received for a service differs from the amount set forth in the applicable provider agreement or paid by Medicare, as applicable, the provider has the right to dispute the payment amount by following WyoBlue's two-level payment dispute process described below.

Two-Level Payment Dispute Process (Available to Contracted Providers)			
First Level Payment Disputes	Provider Request Filing and Deadline	Payment amounts must be disputed within 120 calendar days from the date payment is initially received, unless otherwise specified in the provider's contract. Appropriate documentation must be submitted to support the provider's first-level payment dispute request. Additional information about appropriate documentation for this request is included below the table.	
	Submission Information for contracted providers	Write to: WyoBlue Advantage Appeals & Grievances PO Box 21012 Eagan, MN 55121	Fax: 855-595-2683
	Submission Information for non-contracted out of state providers	Submit to: Provider's local BCBS plan	
	*Independent clinical laboratories and DME/orthotic/prosthetic suppliers should review Section 4, Claims Submission, to determine the appropriate plan.		

Two-Level Payment Dispute Process (Available to Contracted Providers)		
	WyoBlue Response Information	WyoBlue will review the payment dispute and respond to the provider within 60 calendar days from the time WyoBlue receives notice of the first-level payment dispute request. If we agree with the provider's position, then WyoBlue will pay the provider the correct amount. WyoBlue will inform the provider in writing if the first- level payment dispute is denied.

Two-Level Claim Payment Dispute Process (Available to Contracted Providers)			
Second Level Payment Disputes	Provider Request Filing and Deadline	After completing the first level payment dispute process as described above, if a provider still believes that WyoBlue has reached an incorrect decision regarding a payment dispute, the provider may file a request for a second-level review of this determination within 60 calendar days of receiving written notice of WyoBlue's first level decision. Appropriate documentation must be submitted to support the provider's second-level payment dispute request, along with a copy of the first-level decision letter. Additional information about appropriate documentation for this request is included below the table.	
	Submission Information for Contracted providers	Write to: WyoBlue Advantage Appeals & Grievances P.O. Box 21012 Eagan, MN 55121	Fax: 855-595-2683
	Submission Information for non-contracted providers outside WY	Provider's local BCBS plan	
	*Independent clinical laboratories and DME/orthotic/prosthetic supplies should review Section 4, Claims Submission, to determine the appropriate plan.		
	WyoBlue Response Information	WyoBlue will review the payment dispute and respond to the provider within 60 calendar days from the time WyoBlue receives notice of the provider's second-level payment dispute request. Again, if WyoBlue agrees with the provider's position during this second-level review, then WyoBlue will pay the provider the correct amount. WyoBlue will inform the provider in writing if the provider's second-level payment dispute is denied.	
	Note: WyoBlue's second-level payment dispute decisions are always final and binding		

	on the provider.

As noted above, appropriate documentation for a provider's first-level and second-level payment dispute review requests must be submitted, including:

- Completed Provider Appeal Form located here: Provider Resources – WyoBlue Advantage, or the same information in a similar format that includes:
  - Urgency
  - Provider or supplier contact information including name and address
  - Member information
  - Type of appeal
  - Claim information
  - Reason for dispute - a description of the specific issue
- Pricing information such as interim rate letter or pricer documentation, including NPI number (and CCN for institutional providers), ZIP code where services were rendered, and physician specialty
- Copy of the plan's original pricing determination

Part D Prescriber Enrollment Information

Overview

In a final rule published on April 16, 2018 (CMS-4182-F), CMS rescinded the requirement that a provider be enrolled in Medicare in order for their prescriptions to be coverable under the Medicare Part D program beginning 2019. In the same rule, CMS implemented as an alternative that the provider must not be on a preclusion list in order for the drug to be coverable under the Medicare Part D program. Please refer to the following website for more information on the Preclusion List.

In addition, for Part D claims to adjudicate appropriately, eligible prescribers must ensure their taxonomy information is accurate in the CMS National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) registry. You can search https://npiregistry.cms.hhs.gov/registry/ to verify the taxonomy code(s) associated with your NPI. The taxonomy code is an element Prime Therapeutics uses to determine whether a claim may be paid based on eligibility to prescribe.

If you have any questions, please contact your Medicare Administrative Contractor (MAC). Learn more at https://www.cms.gov/MAC-info.

Enrolling in Medicare Part D

You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System located at https://pecos.cms.hhs.gov/pecos/login.do or by completing the paper CMS-855I or CMS-855O application, which is available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.

Note: An application fee is not required as part of your application submission.

Medication Therapy Management Program

Overview

To be eligible for participation in a Medication Therapy Management (MTM) program, a patient must meet the following criteria:

- Have at least three core chronic medical conditions such as hypertension, hyperlipidemia, diabetes, congestive heart failure, or COPD
- Be on at least eight Part D maintenance medications
- Be reasonably expected to incur a predetermined amount of drug expenses in one calendar year as defined by Medicare.

Our MTM program is coordinated by a vendor, OptumRx. All new patients eligible for the MTM program receive a welcome packet that explains the program details and invites the patient to complete a Comprehensive Medication Review. The CMR is an interactive consultation between the patient or the patient's representative and a pharmacist. OptumRx conducts CMRs telephonically from five remote call centers located in several different states once the patient is enrolled in the program.

The CMR generally lasts approximately 30 minutes and reviews every medication the patient takes (including prescription, over-the-counter products, supplements, herbals, physician samples) for potential drug interactions, adherence problems, low-cost alternatives, etc. The pharmacist asks open-ended questions to ensure patients understand their personal medication regimen.

The patient receives a written summary of the CMR within 14 days, with a complete updated medication list and an explanation of any medication issues that were discussed. If any issues were identified

during the CMR, the pharmacist will contact you, as the prescriber, by phone and/or fax to address these issues. Per CMS, everyone who is eligible for the MTM program must be offered a CMR at least once a year. In addition to the mailing, identified patients may be called by an OptumRx call center to encourage their participation. CMR completion rate factors into our overall Star rating scores as a single weighted performance measure.

Per CMS, all MTM program-eligible patients must also receive a targeted medication review at least once every quarter. This is a clinical review of a patient's claims by a pharmacist. If the pharmacist notices any issues, he or she will contact the patient and the patient's prescriber. This is another way the pharmacist can engage the patient to participate in a CMR if they have been unsuccessful in contacting the patient previously.

Pharmacy treatment improvement opportunities

Overview

In addition to our formularies, prescribing limits, and restrictions, we promote quality of care by monitoring claims to improve outcomes and patient safety. CMS requires us to identify certain treatment opportunities and proactively address them with you and your patients. Some of these medication issues factor into our Star rating scores.

High-risk medications

Certain medications pose a high risk of serious side effects in older patients, as described in the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. WyoBlue Advantage and CMS endorse the Beers Criteria. When a routine claim review identifies an instance when a high-risk medication is prescribed, we alert you, as the prescriber, of the risk and offer safer alternatives.

Medication adherence

We pay close attention to medication adherence for disease states such as diabetes, hypertension, and hypercholesterolemia. We monitor medication adherence rates by reviewing pharmacy claims data, and if a patient is non-adherent to their medications, we will address this with the patient to see why the patient is not taking his/her medication as prescribed.

Statin use in diabetes

The guidelines of several medical societies state that diabetics should be on a statin, regardless of whether they have high cholesterol or not, to prevent cardiac events such as heart attacks. We will alert you, as the prescriber, when you have patients with diabetes that are not on a statin.

Opioid overutilization

Because of the risks involved with opioid and acetaminophen use, both WyoBlue Advantage and CMS urge physicians to prescribe opioids with caution and carefully monitor patients using these medications. CMS requires WyoBlue Advantage to actively monitor claims data for potential opioid and/or acetaminophen overuse. If our analysis suggests potential overuse, we send a letter to you, as the prescriber, detailing our concerns and ask you to complete and return a questionnaire about your patient's condition and treatments. If you verify that the current opioid therapy is medically necessary, safe, and appropriate for your patient, we'll follow up with a letter of confirmation and report our findings to CMS.

If you fail to respond to our request for information or agree that the current opioid therapy is not appropriate, WyoBlue Advantage may stop or limit coverage for the patient's opioid medication, notify your patient and you, and report our findings to CMS.

Our analysis looks at:

- Safety risks, such as instances when a patient receives a daily dosage of opioids — either from a single prescription, or multiple prescriptions — that is higher than established safety levels.
- High utilization patterns, where a patient may have opioid prescriptions from multiple physicians within the same time period.
- Potential fraud, waste, or abuse, when a patient visits multiple providers to expand their access to these painkillers, a practice known as "doctor shopping."

Immunization

Coverage

Medicare Part B and Part D both cover certain immunizations. Although the delineation of coverage is fairly clear, there are some exceptions where a vaccine could be covered under either plan.

When billing for prophylactic immunizations, the following always applies:

- Influenza, pneumonia, and COVID-19 (and booster) immunizations are always paid under Part B. (These are never covered under Part D.)
- Shingles and Respiratory Syncytial Virus (RSV) immunizations are always paid under Part D. (These are never covered under Part B.)

Part B covers two categories of immunizations (prophylactic and injury/disease-related), and the benefit pays all charges associated with the vaccination in a single claim, including ingredient cost, dispensing fee, and injection or administration fee. Medicare will pay for immunizations in various venues: at a pharmacy, a clinic, or a provider's office.

Activities associated with administering Part D vaccinations are also bundled into a single claim. However, incidental activity, such as an office visit, may involve additional cost-share to the patient.

Type of immunization	Part A covers	Part B covers	Part D covers
Prophylactic immunizations associated with a senior population: Seasonal influenza Pneumococcal pneumonia Hepatitis B COVID-19 (and booster) Respiratory Syncytial Virus (RSV)	Not applicable.	Influenza, pneumonia, COVID-19 (and booster), and hepatitis B vaccines for patients at high or intermediate risk of contracting the disease.	Hepatitis B vaccine may be covered if the patient does not meet Medicare's Part B criteria. RSV vaccine

Vaccines administered by a health care provider for treatment of an injury or as a result of direct exposure to a disease or condition.	Vaccines administered during an inpatient stay.	Limited vaccines administered on an outpatient basis.	Shingles vaccinations and other Part D vaccines.
		Some vaccines subject to review of clinical criteria to determine Part B or Part D coverage.	Some vaccines (other than shingles) subject to review of clinical criteria to determine Part B or Part D coverage.

Medicare Part B covers influenza, pneumonia, and COVID-19 vaccinations in full. Some organizations provide the influenza vaccination free of charge while others may charge for it. It's important to remind these patients that Medicare Part B covers annual influenza and COVID-19 vaccinations at 100 percent (no copay or deductible). The claims must be submitted under Part B because influenza, pneumonia, and COVID-19 vaccinations are never paid under Part D.
Members are able to receive their Part B influenza, pneumonia, and COVID-19 vaccinations at any participating network pharmacy (where vaccines are available) at no cost under their WyoBlue Advantage PPO Part B vaccine coverage. Please remind patients to use their current WyoBlue Advantage ID card to obtain these Part B vaccinations. If your organization/venue does not file Part B claims on patients' behalf, please inform patients that they can seek reimbursement from Medicare Part B.

Starting Jan. 1, 2023, adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including the shingles vaccine, will be available to people with Medicare Part D at no cost to them as part of the Inflation Reduction Act.

Note: Although shingles and RSV vaccinations are a prophylactic measure, these vaccinations are always covered under Part D. There is no coverage for these vaccinations under Part B.

Billing guidelines for roster bills

Providers who are mass immunizers, and/or providers who choose to bill using the roster billing method, must submit immunization claims on a roster bill and accept assignment under Original Medicare on both the administration and the vaccine. Providers enrolled in the Medicare program should follow the billing guidelines below when submitting roster bills to WyoBlue Advantage:

- At this time, WyoBlue Advantage can only accommodate roster billing on paper claims.
- Providers may submit up to three rosters on a single CMS-1500 claim form for each type of vaccination.
- Rosters may include information regarding multiple patients.
- Typed rosters are preferred.
- Do not fold your claim or roster forms.

Mail your CMS-1500 claims and attached roster bills to:

Roster billing address	WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan MN 55121

Hospital settlements

Settlement

Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted that are at least partially reimbursed based on their reasonable costs rather than a fee schedule. The Medicare Fiscal Intermediary/Administrative Contractor will attempt to make the interim payments as accurate as possible.

After the hospital's fiscal year end, the fiscal intermediary settles with the providers for the difference between interim payments and actual reasonable costs.

CMS policy does not require plans to agree to settle with providers. WyoBlue Advantage conducts settlements on hospital claims for WyoBlue Advantage patients, when requested, where certain provisions of the Original Medicare reimbursement system are not accounted for through the normal claims vouchering system (for example, disproportionate share, bad debt, capital for a new hospital for first two years, etc.) Bad debt and critical access hospital settlements include both inpatient and outpatient claims for

WyoBlue Advantage patients. All other outpatient reimbursement issues should be referred to your provider relations consultant.

To minimize financial impact of the settlement and to ensure proper reimbursement throughout the year, hospitals are expected to retrieve their current year rates from the Fiscal Intermediary/MAC and submit their rate letter (or system equivalent) to the BCBSWY provider contracting department at PO BOX 2266, Cheyenne, WY 82003.

WyoBlue Advantage conducts settlements on a hospital's full fiscal year at the appropriate Medicare rate based on discharge date. WyoBlue Advantage reviews the Medicare Cost Report, the specific claims submitted for review, and the interim rate letters to determine the cost settlement.

The hospital must request a settlement from WyoBlue Advantage in writing within 180 days of the hospital's fiscal year end, and must include the following information:

- A description of the issue
- An estimate of the impact
- Supporting documentation, including (as appropriate):
    - The filed Medicare Cost Report for the year in question
    - The Medicare interim rate letter (or system equivalent) for the applicable time period
    - A detailed WyoBlue Advantage claims list (a template will be provided)
    - Calculations showing how the impact amount was determined

WyoBlue Advantage reviews the information and gives a written determination of funds owed to you from WyoBlue Advantage or funds owed to WyoBlue Advantage from you. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

WyoBlue Advantage reimburses bad debt claims only for uncollected WyoBlue Advantage patient liability. Charges for non-covered services are not included. The hospital must provide a signed attestation that it defines and calculates its bad debt numbers in accordance with the CMS rules and guidelines. The WyoBlue Advantage bad debt claims template, along with the attestation, are provided upon receipt of the request for settlement.

WyoBlue Advantage pays Critical Access Hospital (CAH) claims on an interim basis using the per diems and percentage of charges stipulated in the Fiscal Intermediary/MAC interim rate letter applicable to the date on which services are provided. The cost-based reimbursement rate and elected payment method used for the year under review are compared to the rate calculated on the Medicare Cost Report and a settlement is made based on the difference. Once a hospital elects to engage in the settlement process, all subsequent years will need to be settled.

WyoBlue Advantage reviews the information and gives a written determination of funds owed to you from WyoBlue Advantage, or funds owed to WyoBlue Advantage from you. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

Serious adverse events versus conditions present on admission

WyoBlue Advantage plans do not pay for medically unnecessary services, regardless of the cause. The main provisions of the policy are:

- WyoBlue Advantage will not reimburse a hospital or physician whose direct actions result in a serious adverse event.
- Serious adverse events affected by this policy will be updated as needed to remain consistent with changes made by the Centers for Medicare & Medicaid Services.
- WyoBlue Advantage participating hospitals are required to report if a diagnosis was present on admission (POA) using POA indicators on all claims.
- WyoBlue Advantage participating hospitals are not to balance bill patients for any incremental costs associated with the treatment of a serious adverse event that WyoBlue Advantage has paid.
- WyoBlue Advantage patients who have been billed in error should report incidents to WyoBlue Advantage as appropriate.
- The policy on serious adverse events applies to all acute-care hospitals, exempt hospital units and critical access hospitals that have signed a WyoBlue Advantage participating hospital agreement.
- WyoBlue Advantage developed the following list of serious adverse events and conditions:
    - Object left in the body after surgery
    - Air embolism resulting from surgery
    - Blood incompatibility
    - Catheter-associated urinary tract infections

- Pressure sores (decubitus ulcers) — Stage 3 or 4
- Vascular catheter-associated infections
- Surgical site infections
  - Mediastinitis following a coronary artery bypass graft surgery
  - Gastric bypass
  - Orthopedic procedures
  - Cardiac implantable electronic device
- Hospital-acquired injuries
  - Falls and fractures
  - Dislocations
  - Intracranial and crushing injury
  - Burns
- Deep vein thrombosis or pulmonary embolism following:
  - Total knee replacement
  - Total hip replacement
- Manifestations of poor glycemic control
- Diabetic ketoacidosis
  - Non-ketotic Hyperosmolar coma
  - Hypoglycemic coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolarity
- Iatrogenic pneumothorax with venous catheterization

Additionally, CMS further defined the following events for easier identification:

- Performance of procedure on patient not scheduled for operation (procedure) — formerly known as surgery on wrong patient
- Performance of correct procedure on wrong side or body part — formerly known as surgery on wrong body part
- Performance of wrong procedure on correct patient — formerly known as wrong surgery

Hospitals participating with WyoBlue Advantage are required to submit present-on-admission (POA) indicator information for all primary and secondary diagnoses, for both paper and electronic claims.

The POA indicator is used to identify conditions present at the time the admission occurs, including those that develop during an outpatient encounter in settings that include the emergency

department, observation, or outpatient surgery. The POA indicator is not required on secondary claims.

Certain code categories are exempt from POA indicator reporting requirements because either they are always present on admission, or they represent circumstances related to the health care encounter or factors influencing health status that do not represent a current disease or injury.

Use the following CMS-established values to indicate POA when submitting data:

Value	Definition
Y	Diagnosis was present at the time of inpatient admission
N	Diagnosis was not present at the time of inpatient admission
U	Documentation is insufficient to determine whether the condition was present at the time of inpatient admission
W	Provider is unable to determine clinically whether the condition was present at the time of inpatient admission
1	Exempt from POA reporting
Blanks	Exempt from POA reporting Note: Blanks are valid only on paper claims.

On electronic claims, the POA data element must contain the letters POA followed by a single POA indicator for every diagnosis reported, as follows:

- The POA indicator for the principal diagnosis should be the first indicator after the POA letters, followed by the POA indicators for the secondary diagnoses as applicable.
- The final POA indicator must be followed by either the letter Z or the letter X, to indicate the end of the data element.

For paper claims, the POA indicator is the eighth digit of the principal diagnosis field in Form Locator 67 on the UB-04 claim and the eighth digit of each of the secondary diagnoses in Form Locator 67, A– Q.

The policy on serious adverse events is administered as follows:

- For DRG-reimbursed hospitals — WyoBlue Advantage uses Medicare severity diagnosis-related groups (MS-DRG).
- When the patient is readmitted to the same hospital and the admissions are combined — Hospitals should follow the current process for combining admissions:
    - If the POA indicator is correctly reported as Y (indicating the condition was present on admission), there is no financial reduction.
    - In cases in which the POA for the serious adverse event was N (indicating that the condition was not present on admission and that, therefore, the readmission was a direct result of the serious adverse event), the two cases are combined and only the first admission is reimbursed.
- When the patient is readmitted to the same hospital and the admissions are not combined — Any readmission with diagnosis associated with a serious adverse event during the initial admission may be selected for audit review to validate its presence on admission.
- When the patient is admitted to a different hospital — When an admission to a second hospital carries a POA indicator of Y, but the treatment is that which is medically necessary to treat the adverse event, the second hospital is held harmless and is reimbursed for the admission.
- When claims are submitted with an invalid POA — Claims submitted with an invalid POA indicator are returned to the hospital for correction and are not entered into the WyoBlue Advantage claims system.

When treatment to correct the adverse event is provided by a hospital or physician not responsible for the adverse event — In all cases, the second hospital and the second physician correcting the adverse event are held harmless. Because the treatment is medically necessary, they are reimbursed.

Clinical research study

If a patient with WyoBlue Advantage coverage participates in a Medicare-qualified clinical research study, Original Medicare will pay you on behalf of the WyoBlue Advantage plan. WyoBlue Advantage will pay for Medicare-covered services that are not affiliated with the clinical trial. Therefore, you must submit claims for Medicare-covered services related to the clinical trial to carriers and fiscal intermediaries, not to WyoBlue Advantage, using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to WyoBlue Advantage, and WyoBlue Advantage will reimburse you accordingly.

Swing beds

Swing beds in a Critical Access Hospital (CAH) are paid according to the CAH methodology.

Swing beds located in non-critical access hospitals are paid using the Medicare skilled nursing facility prospective payment system, which is a per diem payment.

Network participation

Overview

WyoBlue Advantage will give select provider types an opportunity to apply for participation in the WyoBlue Advantage network. Network providers care for WyoBlue Advantage patients, and we reimburse them for covered services at the agreed-upon payment rate. Network providers must sign formal agreements with Blue Cross and Blue Shield of Wyoming to participate in the WyoBlue Advantage network. By signing the agreement, you agree to bill us for covered services provided to WyoBlue Advantage patients, accept our reimbursement as full payment minus any patient-required cost sharing, and receive payment directly from WyoBlue Advantage.

Qualifications and requirements

To be included in WyoBlue Advantage network, providers must:

- Have a national provider identifier (NPI) for submitting transactions
- Meet all applicable licensure requirements in the state and meet WyoBlue Advantage credentialing requirements pertaining to licensure
- Submit paper claims to WyoBlue Advantage
- Provide services to a WyoBlue Advantage patient within the scope of their licensure or certification and in a manner consistent with professionally recognized standards of care
- Provide services that are covered by our plan and that are medically necessary by Medicare definitions
- Meet applicable Medicare approval or certification requirements
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services
- Sign formal agreements with WyoBlue Advantage
- Agree to bill us for covered services provided to WyoBlue Advantage patients

- Accept our reimbursement, along with any patient cost share, as full payment
- Receive payment directly from WyoBlue Advantage
- Not be on the excluded and sanctioned provider lists issued by the U.S. Department of Health and Human Services Office of Inspector General
- Not be a federal health care provider, such as a Veterans' Administration provider, except when providing emergency care
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to patients
- Agree to cooperate with WyoBlue Advantage to resolve any WyoBlue Advantage patient grievance involving the provider within the time frame required under federal law
- For providers who are hospitals, home health agencies, skilled nursing facilities, long-term acute care hospitals or comprehensive outpatient rehabilitation facilities, provide applicable patient appeal notices
- Not charge the patient more than their cost sharing under any condition, including in the event of plan bankruptcy
- Provide certain special services to patients only if approved by Medicare to provide such services (e.g., transplants, Ventricular Assist Devices distribution therapy, carotid stinting, bariatric surgery, PET scans for oncology, or lung volume reduction). The list of special services will be automatically updated as determined by CMS.
- Be in good standing with WyoBlue Advantage and meet and maintain all WyoBlue Advantage credentialing requirements for network inclusion. Examples of being in good standing are:
    - Unrestricted license to practice — No license limitations
    - No Medicare or Medicaid exclusion, sanction, or debarment — Not opting out of Medicare
- Agree to accept all WyoBlue Advantage patients unless practice is closed to all new patients (commercial or Medicare)

Network information and affiliation

Overview

WyoBlue Advantage includes a network of health care providers consisting of primary care physicians, specialists, hospitals, and other health care providers who have agreed to provide services to

WyoBlue Advantage patients. The WyoBlue Advantage plans focus on delivering cost-effective and quality patient care. Network providers agree to accept WyoBlue Advantage reimbursement as payment in full for covered services (minus any patient required cost sharing). Patients with WyoBlue Advantage coverage receive services from a select network of providers.

Affiliation

Professional and facility enrollment — If you are an eligible provider who meets the above network participation requirements and would like to enroll with WyoBlue Advantage, contact us at: 1-888-666-5188

Eligible providers — Providers eligible for affiliation with WyoBlue Advantage are:

- Medical Doctors
- Doctors of Osteopathy
- Doctor of Chiropractic Medicine
- Doctor of Dental Surgery (oral surgeons only)
- Doctors of Podiatric Medicine
- Anesthesia Assistants
- Audiologists
- Certified Nurse Providers
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Independent Physical Therapists
- Occupational Therapists
- Optometrists
- Hearing aid dealers
- Fully licensed psychologists (Medicare-eligible)
- Licensed Clinical Mental Health Counselor
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Ambulance providers
- Independent speech language pathologists
- Clinical nurse specialist
- Physician Assistants

Facility affiliation — Facilities eligible for affiliation in the WyoBlue Advantage network are:

- Ambulatory surgical facilities (free-standing only)
- End-stage renal disease facilities (hemodialysis centers)
- Federally qualified health centers
- Home health care facilities
- Hospitals

- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Rural health clinics
- Skilled nursing facilities

Providers participating in WyoBlue Advantage are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act (32 USC 3729, et seq.) and the Anti-kickback Statute (section 128B(b) of the Social Security Act).

WyoBlue Advantage is prohibited from issuing payment to a provider or entity that appears on the List of Excluded Individuals/ Entities as published by the U.S. Department of Health and Human Service Office of Inspector General or on the list of debarred contractors as published by the U.S. General Services Administration (with the possible exception of payment for emergency services under certain circumstances). Providers can access additional information as follows:

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at https://exclusions.oig.hhs.gov/
- The General Services Administration list of debarred contractors can be found in the System for Award Management website at https://sam.gov

Fraud, Waste, and Abuse

Detecting and preventing fraud, waste, and abuse

WyoBlue Advantage is committed to detecting, mitigating, and preventing fraud, waste, and abuse. You are also responsible for exercising due diligence in the detection and prevention of fraud, waste, and abuse, in accordance with the WyoBlue Advantage Detection of Fraud, Waste and Abuse policy. WyoBlue Advantage encourages you to report any suspected fraud, waste and/or abuse to the WyoBlue Advantage Corporate and Financial Investigations department, the Corporate Compliance Officer, the Medicare Compliance officer, or through the anti-fraud hotline at 1-877-411-6950. The reports may be made anonymously.

What is fraud?

Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor (such as WyoBlue Advantage) to get money or a benefit.

Examples of fraud

Examples of fraud include:

- Billing for services not provided
- Billing for services provided to a patient at no cost
- Upcoding services
- Falsifying certificates of medical necessity
- Knowingly double billing
- Unbundling services for additional payment

Providers and vendors are required to take CMS training on Medicare fraud

The Centers for Medicare & Medicaid Services requires providers to take CMS-specific training about fraud, waste and abuse, and compliance. Training is available here.

Providers and vendors should make sure that governing body members and any employees (including volunteers and contractors) providing health or administrative services in connection with the WyoBlue Advantage program complete the training within 90 days of being hired and annually thereafter. Be sure to keep the certificate generated by the website as proof that you took the training and retain evidence of training for 10 years from the end date of your contract with WyoBlue Advantage. You need to be able to provide proof to WyoBlue Advantage or CMS if requested.

What is waste?

Waste includes activities involving payment or an attempt to receive payment for items or services where there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods cause unnecessary costs.

Examples of waste

Examples of waste include:

- Inaccurate claims data submission resulting in unnecessary rebilling or claims
- Prescribing a medication for 30 days with a refill when it's not known if the medication will be needed
- Overuse, underuse, and ineffective use of services

What is abuse?

Abuse includes practices that result in unnecessary costs or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of abuse

Examples of abuse include:

- Providing and billing for excessive or unnecessary services
- Routinely waiving patient coinsurance, copayments, or deductibles
- Billing Medicare patients at a higher rate than non-Medicare patients

Medicare Part D program

As part of an ongoing effort to combat fraud, waste, and abuse in the Medicare Part D program, CMS' program integrity contractor, the NBI MEDIC (Health Integrity, LLC), requests prescriber prescription verifications. The NBI MEDIC routinely mails prescriber prescription verification forms containing the beneficiary's name, the name of the medication, the date prescribed, and the quantity given. The form also asks you to check yes or no to indicate whether you wrote the prescription. You are asked to respond within two weeks. If no response is received, then the investigator follows up with a second request.

A timely and complete response to prescription verification is important, as it's likely to result in the elimination of an allegation of wrongdoing and/or prevent the payment of fraudulent prescriptions without need for further investigation.

Providers who are involved in the administration or delivery of the Medicare Part D prescription drug benefit are strongly encouraged to respond in a timely manner to prescription verifications when contacted by the NBI MEDIC.

Repayment rule

Under the Patient Protection and Affordable Care Act, effective March 23, 2010, you are required to report and repay overpayments to the appropriate Medicare Administrative or other contractor (Fiscal Intermediary or Carrier) within 60 days of the overpayment identification date OR the date that the corresponding cost report is due (if applicable), whichever is later. Failure to do so may render you subject to liability and penalties under the False Claims Act.

Offsets

Overview

WyoBlue Advantage will withhold funds from future claim payment(s) to you up to the amount of any identified overpayment.

Overpayment Offset address	WyoBlue Advantage Insurance Co. PO Box 675508 Detroit, MI 48267-5508

For more information

Contact information

WyoBlue Advantage does not prohibit network health care professionals from advising or advocating on behalf of patients.

Provider Inquiry/Customer Service	If you have general questions about WyoBlue Advantage, call: 1-844-682-9449 Or write: WyoBlue Advantage Provider Correspondence PO Box 21131 Eagan, MN 55121 Fax: 1-855-595-2895
WyoBlue Advantage Anti-Fraud Hotline	If you suspect fraud, please call: 1-877-411-6950 The reports may be made anonymously.

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